S. HRG. 105–592

ACCESS TO CARE: THE IMPACT OF THE BALANCED BUDGET ACT ON MEDICARE HOME HEALTH SERVICES

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

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WASHINGTON, DC

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ACCESS TO CARE: THE IMPACT OF THE BALANCED BUDGET ACT ON MEDICARE HOME HEALTH SERVICES

TUESDAY, MARCH 31, 1998

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 9:55 a.m., in room SD–628, Dirksen Senate Office Building, Hon. Charles Grassley, (chairman of the committee), presiding.

Present: Senators Grassley, Burns, Shelby, Santorum, Hagel, Collins, Breaux, Reid, Feingold, Wyden, and Reed.

Also Present: Senator Baucus.

OPENING STATEMENT OF SENATOR CHARLES GRASSLEY, CHAIRMAN

The CHAIRMAN. I'm going to start the meeting just a little bit early. Yesterday I thought we were going to have a conflict with the Finance Committee that was going to make it very difficult for us to have an orderly meeting. That meeting has been changed, so that we don't have that conflict.

We will have a vote at 10:30, so I presume we're going to have to take a 7 or 8 minute break at 10:30 to cast our vote. But that should not keep us from accomplishing our goal.

I also would like to remind each of our witnesses of the lighting system we have here. The green light, when it's on, means you may continue speaking. When the yellow light comes on, you've got 1 minute to go and when the red light comes on, that would be the end of the 5 minutes. So if some of you think you have a little longer statement than 5 minutes, remember that your entire statement will be put in the record as if read.

Also, on some of the issues we're going to discuss today, at the staff level we've been working with members not only from the Finance Committee and the Aging Committee, but with the bureaucracy, to try to get some of these problems fixed. But we've also been working with non-committee members as well. So there might be some members of the Senate that we've invited to come and participate in today's meeting who are not members of the committee.

Last, I would suggest that sometimes, because of conflicts, members who couldn't come at all would submit questions to be answered in writing, so we would appreciate it very much, if you get

written questions, that those written responses be returned to us in about a two-week period of time.

Now that the hour of 10:00 has arrived, I am going to call the hearing to order.

As chairman of the Special Committee on Aging, it is my pleasure to welcome my colleagues, our witnesses, and members of the public, to this important hearing. This morning I know this hearing is competing with that vote, as I indicated, but I'm sure that we'll be able to get our work done.

Because the Medicare home care benefit primarily benefits older Americans, this Aging Committee is an appropriate forum to discuss these issues. Last year, this committee examined some of the fraud and abuse problems that have troubled the home health program. Let me emphasize that we have not lost interest in stopping fraud and abuse. To me, the two hearings—the one we had last year, plus this one—are two sides of the same coin. Payment problems, or unworkable regulations, threaten access to home care, just as illegal activity does. Both hearings are about preserving the benefits so that our seniors have access to home care, because we all know that it's a very important part of the continuum of care.

I want to make another point, and that is that addressing these issues cannot mean abandoning the fiscal restraint that we need in our entitlement programs. There is a history of tremendous growth in Medicare home health spending in the last 10 years. As this committee has heard again and again, we face a major crisis in funding Medicare when the "baby boomers" retire, and that's now just a little over 10 years away. Preserving Medicare for the next decade was a real victory, but we have to address these home health care issues within the context of that fiscal discipline.

Now, why is home care such an important part of the continuum of care? As citizens often remind us, they prefer to receive care in their homes rather than in institutions. And who wouldn't? I don't know that I've ever met a single citizen of mine who was just itching to get into a nursing home. Rather, it's just the opposite. They want the quality of care that they can get elsewhere before that level of care is needed. So we want to encourage that.

Also, we know that institutional care is expensive. Just ask seniors who have to spend down their assets in order to get into a nursing home. Or you can even ask any State Medicaid director. There is no doubt that home care can be much more cost-effective for the Medicare program than institutional care. In many States, such as Iowa, there are simply no empty nursing home beds. All this is to say that access to home health care is not a luxury for our seniors; it's a necessity. We just have to make this program work.

All of us in the Senate have heard a lot of concern about home health issues, but those of us on the Finance Committee are sort of on the front lines. Senator Breaux and I have been part of a group of Finance members who have been examining the effects of the Balanced Budget Act home health care provisions and weighing proposals to adjust them as needed. I want to emphasize that it is a bipartisan group, because Senators in both parties know how important home care is.

Now, I want to be frank about my concerns on these issues. The surety bond issue is one that's causing a lot of frustration. This requirement was based on the experience of the Florida Medicaid program, where the bonding process served as a screen, keeping fly-by-night operators out of the system. I believe that's what we in Congress thought we were getting in this Balanced Budget Act.

But HCFA's rules have made the bonds a vehicle for HCFA to recover overpayments to agencies. Some of our witnesses today will talk about the availability of bonds under this approach. Several of us on the Finance Committee have written to HCFA to explain what Congress' intention was. While HCFA has made some modifications to its rules, it continues to argue that they are an appropriate way to recover overpayments. One of the issues for us to examine this morning is whether all reputable agencies will ever be able to obtain bonds and participate in Medicare and Medicaid under this philosophy. For rural areas, where there may be only one or two agencies, this becomes a very critical question.

Another area that I'm concerned about is the Interim Payment System. The most troubling thing about this is that it seems to reward agencies that were costly in the past, while punishing agencies that were cost-effective. A town may have two agencies, one with high costs and one with low costs. Why should we be willing to pay much more to that expensive agency when we don't know that its patients are any sicker? Will the low-cost agency have to stop accepting patients with more serious health needs? Will it even be able to stay in business? What effect would that have on seniors' access to home care in that town?

On the venipuncture issue, there seems to be a lot of confusion about exactly how many seniors have been affected by that change of policy. I would expect that many of those affected would have a need for another skilled service, and thus, would still be eligible for home health. But are there many seniors for whom that's not the case? I hope that we'll be able to get some facts on that question.

I note that the Interim Payment System and the new venipuncture policy would be harder to change than the surety bond issues. That's because they would require congressional action. There's a lot of reluctance on the Hill to do any Medicare legislation this year, especially because any bill would not be protected by reconciliation rules. But the chances of any legislation would certainly be improved if HCFA supported these changes. So, in addition to Ms. DeParle's views on the surety bond regulations, I am also anxious to hear whether HCFA believes that any legislation is needed on any of these three issues.

On our second panel we have a number of witnesses from the home care community testifying on these three issues. One of them is one of my constituents, so I extend a special welcome to her. Let me emphasize this is meant to be a fair hearing, where both HCFA and the home care community will be able to air their views. Let's all agree to adopt a cooperative attitude and let us all recognize that we share the goal of preserving access to home care.

[The prepared statement of Senator Grassley follows:]

SENATE SPECIAL COMMITTEE ON
AGING

Senator Chuck Grassley, Iowa, *Chairman*
Senator John Breaux, Louisiana, *Ranking Member*

Opening Remarks
Senator Charles E. Grassley
Chairman, Senate Special Committee on Aging
Hearing on Access to Care:
The Impact of the Balance Budget Act on Medicare Home Health Services
March 31, 1998

This hearing will come to order. As Chairman of the Special Committee on Aging it is my pleasure to welcome my colleagues, our witnesses, and members of the public to this important hearing. This morning I know this hearing is competing with a key meeting of the Finance Committee on IRS reform-- a big issue for me -- and meetings of some other key committees too. But I'm sure that many of my colleagues will be stopping by when they can.

Because the Medicare home care benefit primarily benefits older Americans, the Aging Committee is a natural forum for these issues. Last year, this Committee examined some of the fraud & abuse problems that have troubled the home health program. Let me emphasize that we have not lost interest in stopping fraud & abuse; to me, the two hearings are two sides of the same coin. Payment problems, or unworkable regulations, threaten access to home care -- just as illegal activity does. Both hearings are about preserving this benefit so that our seniors can have access to home care.

I want to make another point. Addressing these issues cannot mean abandoning the fiscal restraint we need in our entitlement programs. There is a history of tremendous growth in Medicare home health spending in the last 10 years. As this Committee has heard again and again, we face a major crisis in funding Medicare when the baby boomers retire, and now that's just over 10 years away. Preserving Medicare for the next decade was a real victory. We have to address these home health issues within the context of fiscal discipline.

Now, why is home care so important? As citizens often remind us, they prefer to receive care in their homes, rather than in institutions. Who wouldn't? In addition, institutional care is expensive. Just ask seniors who have to spend down their assets in order to get into a nursing home -- or ask their state Medicaid directors. There is little doubt that home care can be much more cost-effective for the Medicare program than institutional care. And in many states, such as Iowa, there are simply not empty nursing home beds. All this is to say that access to home health care is not a luxury for our seniors: it is a necessity. We just have to make this program work.

All of us in the Senate have heard a lot of concern about home health issues, but those of us on the Finance Committee are sort of on the front lines. Senator Breaux and I have been part of a group

of Finance members who have been examining the effects of the BBA home health provisions, and weighing proposals to adjust them as needed. I want to emphasize that it is a bipartisan group, because senators in both parties know how important home care is.

Now, I'll be frank about my concerns about these issues. The surety bond issue is one that's causing a lot of frustration. This requirement was based on the experience of the Florida Medicaid program, where the bonding process served as a screen, keeping fly-by-night operators out of the system. I believe that's what we in Congress thought we were getting in the BBA.

But HCFA's rules have made the bonds a vehicle for HCFA to recover overpayments to agencies. Some of our witnesses today will talk about the availability of bonds under this approach. Several of us on the Finance Committee have written to HCFA to explain what Congress's intention was. While HCFA has made some modifications to its rules, it continues to argue that they are an appropriate way to recover overpayments. One of the issues for us to examine this morning is whether all reputable agencies will ever be able to obtain bonds, and participate in Medicare and Medicaid, under this approach. For rural areas where there may be only one or two agencies, this question is critical.

Another area I'm concerned about is the Interim Payment System. The most troubling thing about the IPS is that it seems to reward agencies that were costly in the past, while punishing those that were cost-effective. A town may have two agencies -- one with high costs, one with low. Why should we be willing to pay much more to that expensive agency, when we don't know that its patients are any sicker? Will the low-cost agency have to stop accepting patients with more serious health needs? Will it even be able to stay in business? What effect would that have on seniors' access to home care in that town?

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I note that the IPS and the new venipuncture policy would be harder to change than the surety bond rules. That's because they would require Congressional action. There's a lot of reluctance on the Hill to do any Medicare legislation this year, especially because any bill would not be protected by reconciliation rules. But the chances of any legislation would certainly be improved if HCFA supported it. So in addition to Ms. DeParle's views on the surety bond regulations, I am also anxious to hear whether HCFA believes that any legislation is needed on any of these three issues.

On our second panel, we have a number of witnesses from the home care community, testifying on these three issues. One of them is one of my constituents from Iowa, so I extend a special welcome to her. Let me emphasize this: this is meant to be a fair hearing, where both HCFA and the home care community will be able to air their views. Let's all agree to adopt a cooperative attitude, and let's all recognize that we share the goal of preserving access to home care.

Now, let me introduce Nancy-Ann Min DeParle, the Administrator of HCFA. Ms. DeParle was confirmed as Administrator late last year, so she wasn't yet on the job when HCFA supported the inclusion of these three items in the BBA. Maybe that'll affect her views of them -- I guess we'll see. Ms. DeParle, I know how busy HCFA is now, and I want to thank you for being here. I understand that you may not be able to stay for the testimony of our second panel, but I hope that your staff will be able to stay and hear it, because I think that listening to one another is an important part of making this hearing a true dialogue. Please begin.

The CHAIRMAN. I would now like to recognize Senator Wyden—I think you were first—and then Senator Shelby and Senator Collins.

STATEMENT OF SENATOR RON WYDEN

Senator WYDEN. Thank you very much, Mr. Chairman.

Let me commend you not for just the inquiry but the bipartisan way in which you're taking it on. You're absolutely right. There is nothing that is partisan about this issue at all. We have some complicated Medicare reimbursement issues to deal with and we appreciate your leadership.

Mr. Chairman and colleagues, the cumulative effect of recent home care policies is producing an ugly double-whammy. First, it is getting tougher for the truly frail and needy older person to get home health care in our country, and second, we are sending a message to responsible providers, responsible providers who hold their costs down, that they are, in fact, going to be penalized for it.

So, in effect, we're getting the worst of both worlds. We're not doing what we need to do to target access to those who are most needy, and then we're sending a message that if you rip off the program, you charge the higher cost, get into the overpayments, we're not going to be as harsh on you as we're going to be on the responsible providers who hold the costs down.

Mr. Chairman, like you, I represent many rural constituents, and we are already seeing home health care programs in rural America on the ropes. You read about it in the newspapers today, and it's going to continue unless we work together on a bipartisan basis to change it. It seems to me that now, as we move from the interim payment system to prospective payment, we will have an opportunity to correct this.

I think, Mr. Chairman, you and I remember some of the challenges we faced with the AAPCC, Average Adjusted Per Capita Cost reimbursement system. This is not unlike that. Folks in the rural areas that are doing a good job have to have a chance to get reasonable reimbursements, and second, we do need a better system for targeting the rip-off artists who try to exploit the program.

One of the things I would like to explore with you, Mr. Chairman and colleagues, is creating what I call a "watch list," where that small number of providers that you do see exploiting the program could, on an ongoing basis, be monitored vigorously to ensure they don't rip off the program, while the 90-plus percent of the home care operators who don't try to exploit the program don't have to be saddled with every manner of red tape and bureaucracy in delivering services.

Finally, I am glad that you're having Nancy-Ann Min DeParle appear as a witness. She inherited a lot of this mess, and I think she has shown a real willingness to help us drain the swamp, and we look forward to working with you.

The CHAIRMAN. OK.

In the order of arrival, Senator Shelby.

STATEMENT OF SENATOR RICHARD C. SHELBY

Senator SHELBY. Thank you, Mr. Chairman.Mr. Chairman, I ask unanimous consent that my entire statement be made part of the record.

The CHAIRMAN. Yes.

Senator SHELBY. Mr. Chairman, I want to associate myself with your remarks, and also the remarks of the Senator from Oregon. I want to thank you for holding this timely hearing.

Mr. Chairman, as you well know, the Balanced Budget Act of 1997 took important steps to begin to combat the financial problems that have plagued the Medicare system for some time. One area that it addressed was the dramatic growth in expenditures for home health care, which has become one of the fastest growing components of Medicare.

In 1985, Medicare program payments for home health benefits totaled 2.5 billion—that is, in 1996 dollars, representing about 2.5 percent of all Medicare payments. By 1966, home health payments grew to 16.7 billion, accounting for 8.7 percent of all Medicare expenditures.

To address these increases, Congress included provisions in the Balanced Budget Act—which a lot of people didn't know about and were really never fully debated on the floor of the Senate—designed to address fraud and abuse in the system and restore a sustainable growth rate to the program, whatever that is. However, several of these provisions have created confusion, as well as other problems, in the home health care industry and among Medicare beneficiaries, the elderly.

In addition to the surety bond requirement, and the move to an interim payment system, the elimination of venipuncture as a qualifier for home health care has created significant concern in my home State of Alabama, as well as other States. Despite assurances from HCFA that no one with serious health ailments would lose their home health care as a result of the venipuncture provision, there are indications that, in fact, a lot of elderly in America may have already lost their home care because of this.

Because of the uncertainty and confusion surrounding this issue, I introduced the Medicare Venipuncture Assessment Act, Senate bill 1580, which is designed to shed light on this situation, part of which you will cover today. The bill would provide an 18-month moratorium on the venipuncture provision and direct the Secretary of Health and Human Services to conduct a study to determine what the specific effects have been from doing away with venipuncture as a qualifying skill.

I have always supported, Mr. Chairman, as you have, efforts to rid the Medicare system of fraud and abuse, but I believe, Mr. Chairman, in our haste to root out the bad apples in the home health care system, Congress must be sure not to harm the very people we're trying to protect from abuse in the system, the elderly.

Mr. Chairman, I thank you for holding this important hearing, and I look forward to hearing some of the testimony.

[The prepared statement of Senator Shelby follows:]

Richard Shelby

Statement by Senator Richard C. Shelby
Home Health Care Hearing
Senate Special Committee on Aging
March 31, 1998

Good morning. I want to thank Chairman Grassley for holding this important hearing. I regret that due to some schedule conflicts I will not be able to attend the entire hearing, but I look forward to reviewing the testimony of this morning's witnesses. In addition, I have questions I would like to enter for the record.

Mr. Chairman, the Balanced Budget Act (BBA) of 1997 took important steps to begin to combat the financial problems that have plagued the Medicare system for some time.

One area that it addressed was the dramatic growth in expenditures for home health care which has become one of the fastest growing components of Medicare.

In 1985, Medicare program payments for home health benefits totaled $2.5 billion (in 1996 dollars), representing about 2.5 percent of all Medicare payments. By 1996, home health payments grew to $16.7 billion, accounting for 8.7% percent of all Medicare expenditures.

To address these increases, Congress included provisions in the BBA designed to address fraud and abuse in the system and restore a sustainable growth rate to the program. However, several of these provisions have created confusion, as well as other problems, in the home health care industry and among Medicare beneficiaries.

In addition to the surety bond requirement, and the movement to an interim payment system, the elimination of venipuncture as a qualifier for home health care has created significant concern in my home state of Alabama.

Despite assurances from HCFA that no one with serious health ailments would lose their home health care as a result of the venipuncture provision, there are indications that in fact some elderly may have lost their home care.

Because of the uncertainty and confusion surrounding this issue, I introduced the Medicare Venipuncture Assessment Act (S. 1580) which is designed to shed light on the situation.

The bill would provide an eighteen month moratorium on the venipuncture provision, and direct the Secretary of Health and Human Services (HHS) to conduct a study to determine what the specific effects have been from doing away with venipuncture as a qualifying skill.

I will always support efforts to rid the Medicare system of fraud and abuse, but in our haste to root out the bad apples in the home health care system, Congress must be sure not to harm the very people we are trying to protect from abuse in the system.

Again, thank you Senator Grassley for holding this hearing. I look forward to learning how we can ensure the integrity of the Medicare system without placing too great of a burden on home health care providers and beneficiaries.

The CHAIRMAN. Before you give your statement, Senator Reid, I invite everybody to speak because, I think, if you come to this hearing, the chairman should give you the right to speak. Usually we don't have this many people who show up, so to the extent you might be able to abbreviate what you say, we would appreciate that.

I have also invited Senator Baucus to be here with us, too, because he's been active in the rural health care issues over a long period of time and I wanted him to be able to speak as well.

Senator Reid.

STATEMENT OF SENATOR HARRY REID

Senator REID. Mr. Chairman, I think it's important that Senator Baucus is here because of his position on the Finance Committee, along with you. I think these issues are something that the whole Senate should be involved in, and I appreciate your holding this hearing. These are issues we've all heard about when we've gone home.

The surety bond issue is something that has created a lot of confusion and trouble and consternation in the State of Nevada. I hear that needed services will no longer be available, as we have indicated here, in rural areas especially, because providers can't obtain surety bonds. Seniors who depend on home health care will now have to rely on institutional care, or more costly alternatives, to obtain needed care to remain in their homes because there will be fewer agencies to provide services.

I am just as concerned on the claims that the only companies that will survive in home health care are those that are hospital-based, or are large enough to comply with the new requirements. There aren't many of those in the State of Nevada.

Mr. Chairman, I know these outcomes were not the intent of Congress when we enacted the Balanced Budget Act, and I again commend you for your leadership in listening from people on both sides of this issue. I didn't support the Senate version of the Balanced Budget Act because I was concerned that we had not adequately assessed the impact on some of the more controversial, untested provisions which called for, for example, a five dollar copay for home health care visits, means testing, and raising the age of eligibility for Medicare.

Some of my concerns also extend to the very details we're addressing today. My point is not to point fingers, but merely emphasize the need for caution when we make sweeping changes. We enact legislation sometimes that has the best of intentions. In this case, Medicare, our goal was to extend the solvency in the hospital trust fund, while long-range solvency challenges are being addressed by the bipartisan Commission on Medicare, led by our able ranking minority member, Senator Breaux. This is something we had to do. However, we may have viewed the legislation from the perspective of 16.2 billion savings over 5 years to be achieved, and not from the perspective of seniors needing home health care or the many providers who deliver this care in regions of the country where few home health care options are available.

Tragically, some interpret this legislation differently than Congress' intent, and this interpretation, sadly, is going to put many

solid, conscientious, hard-working and reputable small home heath care businesses out of business and place the delivery of needed services in question for many seniors. This was not the intent of Congress.

Mr. Chairman, I intend to listen here today. If we have enacted legislation that doesn't follow the intent of Congress, or we allow the promulgation of regulations that don't deliver our intent, then I think we have to act. It was not our intent to have these huge surety bonds that, in effect, put small businesses out of business.

Home health care services must remain available for older Americans. If we're able to promote policies which support aging in place.

I say to my friend from Alabama, it's true that home health care costs have gone up, but the fact that they have gone up has reduced overall Medicare. I think one reason that we don't have the increased spending level is because we've been able to divert some of this to policies like home health care.

There is fraud, and we have the responsibility to address it. However, we must not throw the baby out with the bath water. It's important that we not engage in mass punishment, holding all providers accountable for the bad behavior of a few. But, by the same token, we must not try to solve two policy concerns—fraud and overutilization—with the same policy solution. If we do, I'm concerned that the next policy challenge faced by Congress will be underutilization of home health care services.

By no means should our actions have the unintended consequences of denying coverage to those most vulnerable, the seniors. While home health care beneficiaries make up less than 10 percent of the Medicare population, they are generally poorer, sicker, predominantly female, more likely to live alone, and have more functional impairments. They are truly our most needy.

Again, Mr. Chairman, for the third time here this morning, I commend you for your leadership on this issue, and your fairness. I speak for my constituents in Nevada. We are most grateful.

The CHAIRMAN. Thank you.

Senator Collins.

STATEMENT OF SENATOR SUSAN M. COLLINS

Senator COLLINS. Thank you very much, Mr. Chairman. I, too, want to commend you for holding this very important hearing this morning to explore the impact of the recent changes included in the Balanced Budget Act on the access of our senior citizens to vital home health care services.

America's home health agencies provide invaluable services that have enabled a growing number of our most frail and vulnerable Medicare beneficiaries to avoid hospitalization as well as nursing homes and to stay just where they want to be—in their own homes.

Today, home health is the fastest growing component of Medicare spending, and the program grew at an astonishing average annual rate of more than 25 percent from 1990 to 1997.

This rapid growth in home health care spending understandably prompted Congress and HCFA to initiate changes that were intended to make the program more cost-effective and efficient as well as to protect it from fraud and abuse. However, in trying to

get a handle on costs—and this is probably a lesson to all of us—we in Congress, as well as at HCFA, may have unintentionally created some problems that have restricted Medicare beneficiaries' access to home health care.

For instance, Mr. Chairman, I am particularly concerned that the interim payment system that Congress put in place, and which will remain in effect until HCFA implements a prospective payment system, inadvertently penalizes cost-efficient home health agencies by basing 75 percent of the agencies' per patient payment limits on their fiscal year 1994 average cost per patient. What this system does is effectively reward the agencies that provided the most visits and spent the most Medicare dollars in 1994, while penalizing low-cost and more efficient providers.

The Wall Street Journal had an excellent article on this earlier this year, which I would request be included in the record.

The CHAIRMAN. So ordered.

Senator COLLINS. It said that ironically, New England is getting clobbered by the system because of its tradition of nonprofit community service and efficiency. The article goes on to say, "If New England had just been a little greedier, its home health industry would be a lot better off now." That's the unfortunate result that has been created by the new system.

Moreover, there doesn't seem to be any logic to the variance in payment levels. For example, the cap for Mississippi is expected to be $2,000 more than my home State of Maine, without any evidence that the patients in Mississippi are sicker or that the nurses and other home health personnel in this region cost more.

My concern, Mr. Chairman, is that the current system may force low-cost agencies to stop accepting patients with more serious health care needs. I simply do not think that that's what we in Congress intended. I plan to introduce legislation shortly to deal with this issue.

In the interest of time, I would ask that the remainder of my statement be placed in the record. But I do look forward to working with you, Mr. Chairman, and the other members of this committee, in crafting a legislative solution to this problem.

Again, thank you for holding this hearing.

[The prepared statement of Senator Collins, with attached article, follows:]

Statement of Senator Susan M. Collins
Senate Special Committee on Aging
March 31, 1998
"Access to Care:
the Impact of the Balanced Budget Act on Medicare Home Health Services"

Mr. Chairman, thank you for calling this morning's hearing to examine the impact that the changes made by the Balanced Budget Act to the Medicare home health program are having on seniors' access to care.

America's home health agencies provide invaluable services that have enabled a growing number of our most vulnerable Medicare beneficiaries to avoid hospitals and nursing homes and stay just where they want to be -- in their own homes. As a consequence, the number of Medicare home health beneficiaries has more than doubled from 1.7 million in 1989 to 3.9 million in 1996, and Medicare home health spending has soared from $2.7 billion in 1989 to $17.1 billion in 1996. Today, home health is the fastest growing component of Medicare spending, and the program grew at an astounding average annual rate of more than 25 percent from 1990 to 1997.

This rapid growth in home health spending rightly prompted Congress

and the Health Care Financing Administration to initiate these changes last year that were intended to make the program more cost-effective and efficient and protect it from fraud and abuse. However, in trying to get a handle on costs, Congress and the Health Care Financing Administration may have unintentionally created some problems that restrict Medicare beneficiaries' access to home health care.

For instance, I am particularly concerned that the interim payment system Congress put in place — which will remain in effect until HCFA implements a prospective payment system — inadvertently penalizes cost-efficient home health agencies by basing 75 percent of the agencies' per patient payment limits on their FY 1994 average cost per patient. Giving such a heavy weight to the agency-specific costs per beneficiary effectively rewards agencies that provided the most visits and spent the most Medicare dollars in 1994, while it penalizes low-cost, more efficient providers. As a result, the high-cost and inefficient agencies will continue to receive a disproportionate share of Medicare home health dollars.

Moreover, there is no logic to the variance in payment levels. The

average patient cap in Tennessee is expected to be $2,200 higher than Connecticut's and the cap for Mississippi is expected to be $2,000 more than Maine's, without any evidence that patients in the Southern states are sicker or that nurses and other home health personnel cost more.

I simply do not think that this is what Congress intended, and I plan to introduce legislation soon to level the playing field and make certain that those home health agencies that have been prudent in their use of Medicare resources are not unfairly penalized. Instead of allowing the experience of high cost agencies to serve as the basis for the new cost limits, my proposal would set a new per beneficiary cost limit based on a blend of national and regional average costs per patient. Moreover, by eliminating the agency-specific data from the formula, it will move us more quickly to the national and regional rates which will be the cornerstones of the future prospective payment system, and it will do so in a way that is budget neutral.

Again, Mr. Chairman, I thank you for calling this hearing and look forward to the witnesses' testimony.

THE WALL STREET JOURNAL.

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Region's Home-Care Firms Face Being Punished for Their Efficiency

By CAROL GENTRY
Staff Reporter of THE WALL STREET JOURNAL

If New England had been just a little greedier, its home-health industry would be a lot better off now.

In a rush to cut Medicare spending, Congress has set up a home-health payment system that punishes low-cost agencies and states, while it rewards big spenders and regions where audits have found widespread fraud and abuse. Ironically, New England is getting clobbered by the system because of its tradition of nonprofit community service and efficiency.

And patients are feeling the effects. In the past two weeks, about 30 complaints have come into the Boston office of the federal agency that must implement the change, the Health Care Financing Administration. The agency says the complaints are coming from patients who need frequent, long-term nursing visits, but say they are being turned away or cut off.

"I fear we're now looking at home health agencies dumping [expensive] patients," says Margaret Leoni-Lugo, chief of the HCFA quality-improvement branch for New England. Such discrimination violates state and federal regulations.

Ms. Leoni-Lugo says she sympathizes with the difficult situation confronting New England agencies, but cannot condone patient dumping. Today she is expected to hold a telephone conference with health-department officials in the six New England states, warning them to watch for evidence that agencies are cutting care too much.

"We want to keep the beneficiaries safe," says Ms. Leoni-Lugo.

The New Formula

The new system rolls back payments to 1993-94 levels minus 2%, regardless of whether an agency's budget was low or grossly inflated during those years. Under the system, home-health agencies' Medicare payments will be affected not only by their own budget history, but also by their location. If a company is in a penny-pinching region, its payments will be lower than if it comes from an area of big spenders. The agencies that come out best under this formula are those that spent money willy-nilly five years ago and were surrounded by companies that did the same thing. The biggest winners will be states in the South.

Meanwhile, frugal agencies in regions

Yankee Thrift

Home-health agencies in the New England states have delivered care for less money than the national average both in Medicare payments per visit and per patient. Data shown here are from 1995.

	NUMBER OF PATIENTS, IN THOUSANDS	AVERAGE PAYMENT PER VISIT	PCT. ABOVE OR BELOW NATIONAL AVERAGE	AVERAGE PAYMENT PER PATIENT	PCT. ABOVE OR BELOW NATIONAL AVERAGE
Connecticut	57	$60	-3.0%	$4,770	6.6%
Massachusetts	119	50	-19.0	4,730	5.7
Rhode Island	19	64	3.0	4,037	-9.7
Maine	22	53	-15.0	3,717	-16.9
New Hampshire	17	50	-19.0	3,057	-31.7
Vermont	12	45	-28.0	3,030	-32.3
NEW ENGLAND	246	53	-15.0	4,400	-1.6
U.S.	3,430	62		4,473	

Sources: Health Care Financing Administration and The Wall Street Journal

England, the Midwest and the Mountain states — are reeling. Vermont, New Hampshire and Maine will be among the hardest-hit states in the nation. Massachusetts, Connecticut and Rhode Island fare only marginally better.

Advocates for the elderly and the region's home-health agencies say such a system gives a competitive advantage to the worst players in the industry. "This is not in the best interest of taxpayers," says Susan Young, executive director of the Home Care Association of New Hampshire.

Adds Margaret Gilmour, president and chief executive officer of Home Health & Hospice Care, a home-care agency in Nashua, N.H.: "This is going to be a tidal wave of disaster for elder care."

Layoffs are already under way in New Hampshire, Ms. Young says, where the industry is among the leanest in the nation.

The congressional delegation from Massachusetts hopes to derail the new system before it can do massive damage. "This defies common sense," says Rep. James P. McGovern, a Democrat from Worcester. "This is a big, fat mistake."

Taking Care of the Homebound

In late November, Rep. McGovern and 11 other members of the state's congressional delegation sent a letter of concern to HCFA. The group hopes to meet with top agency officials in Washington soon.

Home-health agencies send nurses, to the homes of patients who are so physically or mentally disabled that they cannot easily go or be taken to a medical clinic.

While most private insurers and health-maintenance organizations cover home health care, the main money pipeline is Medicare. All homebound elderly and disabled beneficiaries of the program are eligible for free unlimited visits, as long as the visits are part of a treatment plan that is authorized by a physician and is updated every two months.

There are several types of home-health agencies, including the community-based nonprofits, such as the Visiting Nurses Associations of America; the newer for-profit companies; and hospital-affiliated agencies. Medicare's costs have been higher for patients who go through one of the hospital or for-profit companies.

Hospital-affiliated agencies tend to have higher per-visit costs than independent ones because they can legally transfer some of the hospital's overhead to the home-health books and have Medicare pay for it. For-profit agencies tend to generate higher Medicare payments by billing for a greater number of visits per patient.

Patients recuperating from surgery or a short-term illness may need only a few visits, but home-health agencies are a lifeline for patients with long-term conditions — multiple sclerosis, Alzheimer's disease, heart failure, severe diabetes — who are trying to stay out of nursing homes.

The new system sets an annual limit on

Home-Care Firms to Suffer for Being Efficient

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? amount that Medicare will spend on ..y given patient. While that cap is different for every agency, it averages out to 75 visits a year in Massachusetts. Patient advocates say this gives agencies an incentive to take on only those clients who are going to get better or die in a short time.

To make matters worse, agencies must reduce expenses without knowing just how deep the cuts will be. The details of the payment formula won't be determined until April 1, but will be retroactive to Oct 1.

Seeking Formula Change

In the letter to HCFA, the Massachusetts delegation asked administrators to alter the new formula to "lessen the blow" to low-cost, efficient home-health agencies. The letter says it is unfair to tag payments to a 1994 average per-patient cost of $4,328 in Massachusetts, when Tennessee was getting $6,508 and Louisiana $6,700.

Rep. McGovern says he hopes to repeal the payment-system provision when Congress convenes later this month, but he knows that may not be easy. Many of the leaders of Congress are from the South, where payment rates are projected to be double those in much of New England.

Massachusetts has a lot at . In 1995, the last year for which Medicare has complete data, the program spent more than $1 billion in New England to provide home health to 246,000 beneficiaries. Of that money, Massachusetts absorbed more than half for 119,000 homebound patients. More than 14% of the state's Medicare beneficiaries were served by home care, while the rate was about 10% nationwide.

Under the new payment system, members of the Massachusetts delegation say, their state stands to lose $95 million and at least 1.5 million patient visits in the first year.

Why will the system affect Massachusetts so much? The state's home-health agencies deliver care at a more moderate cost per visit than most other states, federal data show, but also perform more visits per patient, on average. Pat Kelleher, executive director of the Home Health Care Association of Massachusetts, says one reason is that the state has deliberately pushed home care to save state tax money. Federally paid Medicare home-health visits keep patients out of nursing homes, which draw most of their revenue from the state Medicaid program.

Time Ahead for Vermont

e other New England states affected, Vermont, the only state that legally requires home-health companies to be nonprofit, especially faces troubled times. After consistently providing home care at the lowest cost per patient in the nation, Vermont's 13 agencies stand to lose more than $2 million this year and estimate they will have to reduce service by 10%.

The Vermont Assembly of Home Health Agencies estimates the average per person payments in the state this year will be $2,600 a year, less than half what the payout is expected to be in, say, Alabama.

"The system was supposed to limit the high rollers," says the association's director, Peter Cobb, but instead "Congress rewarded excess."

The rule changes stem from the passage last August of the Balanced Budget Act, which cuts $115 billion from Medicare by 2002. The home-care portion of the act slices $16.2 billion from the budget.

Home care seemed a logical place to look for cuts, since it's the fastest-growing segment of the health industry. Between 1990 and 1995, while the number of Medicare beneficiaries rose 10%, the number of home-health visits grew 255% and spending went up 316%.

Some of that increase accompanied the rise of managed-care companies that try to keep patients out of the hospital to save money and, if they must go, keep the visits as brief as possible. However, much of the inflation in home care was a predictable response to a payment system that offered no incentive to be frugal.

Probe Finds Waste, Fraud

Massive fraud, waste and ineptitude in Medicare billings were reported last summer by the Office of the Inspector General of the U.S. Department of Health and Human Services following a two-year investigation called Operation Restore Trust. The study covered five states that account for 40% of Medicare payments: California, New York, Florida, Texas and Illinois.

The report said one-fourth of home-health agencies in those states received nearly half the Medicare dollars spent on home-health care. According to the report, the "problem" agencies tended to be for-profit, closely held corporations with owners that were involved in a tangle of interlocking, self-referring businesses. Texas was cited as the biggest home-health spender of the states studied. (An HCFA audit conducted in Massachusetts and Connecticut last year found a few overpayments, but no cases of fraud.)

It just so happened that the revelations of Operation Restore Trust occurred at the same time that Congress was looking for ways to cut Medicare spending.

Congress wanted to change the home-health payment system so that it would reward efficiency, by switching to a flat rate by diagnosis. This "prospective payment system" would be similar to the one that Medicare uses to pay hospitals.

But HCFA said it needed more time to develop the complex formula to set prospective payment in motion. So Congress created an interim system that will run until Oct. 1, 1999. It freezes spending at the rates that were in place in 1993-94 — *before* Operation Restore Trust began.

Varying Payments

Now payments vary illogically. The average patient cap in Tennessee is expected to be $2,200 higher than that in Connecticut, and the cap for Mississippi $2,000 more than Maine, without any evidence that patients in the Southern states are sicker or that nurses cost more there.

But those who think the Southern states are pleased at getting a patient cap double that of New England are mistaken. Officials at the Texas Association for Home Care say they need bigger payment rates because they have a high rate of poor elderly who have never had proper health care, and the state Medicaid program hasn't taken care of them because it's stingy.

"Congress has cut into the bone," says Sara Speights, director of government and public relations for the Texas group.

Inequities exist even within the same region. Ms. Gilmour of the Nashua, N.H., home-care agency says a competitor in northern Massachusetts could end up with a payment cap twice as high as her own as a result of her staff's efforts to keep costs down. Because patients are free to choose either agency, she worries they will gravitate to the one that has a bigger budget.

Joan Hull, chief executive of the nearby competitor, the Home Health Visiting Nurses Association of Haverhill, Mass., says her agency is a product of a merger between agencies that had different payment rates, so she doesn't know whether the Medicare cap will be $3,400 or $4,600 per patient. Unfortunately for her agency, services it has delivered since the beginning of its fiscal year in October will be on the new payment rate, but the agency won't know what the rate is until April.

"It's crazy, isn't it?" Ms. Hull says with a laugh.

Big Spenders

While Medicare costs for home-health services have gone up 25% nationwide, 5 chief states led the spending spree. The new payment system rewards states where payments were far above average, as shown below. (Data are for 1995.)

	# OF VISITS PER PATIENT	AVG. PAYMENT PER PATIENT	PERCENT ABOVE NATIONAL AVERAGE
Louisiana	144	$7,867	75.9%
Oklahoma	127	7,358	64.5
Texas	117	7,217	61.3
Tennessee	121	6,886	53.9
Utah	106	6,283	40.5
Mississippi	128	6,205	38.7
THE SOUTH	95	5,488	22.7
U.S.	72	4,473	

Sources: Health Care Financing Administration and The Wall Street Journal

The CHAIRMAN. I think you can see the turnout that we have of our members here, as well as people standing in the room from the public who are here, that this is a tremendous problem that must be dealt with. Everybody is here to show their concerns.

Senator Feingold.

STATEMENT OF SENATOR RUSSELL D. FEINGOLD

Senator FEINGOLD. Thank you, Mr. Chairman.

Let me not only thank you for this hearing but for your leadership on the committee. I feel that you are really helping us identify the issues that are appropriate, and an opportunity for this committee to do very good work. This is a classic example.

Like all of you here this morning, I am deeply concerned about the impact of the Medicare home health provisions that were included in the Balanced Budget Act. I have been working on issues surrounding home health care and long-term care for my entire public life, and I believe strongly in the importance and the availability of home health care because it is integral to enabling people to stay in their own homes for a longer period of time.

I recognize, Mr. Chairman, that there have been cases of egregious fraud and abuse documented in certain Medicare home health care programs. But, based on my experience with home health care providers in Wisconsin, my feeling is that we have to proceed cautiously and thoughtfully, to make sure Federal Government efforts do not impair the ability of the legitimate, above-board providers' ability to provide this important service.

As the Senator from Oregon was indicating, States like Wisconsin, and other States in the upper Midwest, have long had a high efficiency, low-cost Medicare home care provider tradition. As such, under the interim payment system and its associated per-beneficiary cost limits based on fiscal 1994 costs, Wisconsin home care providers effectively are going to be punished for being efficient service providers.

Let me tell you, I've heard this first hand. I go to every one of Wisconsin's 72 counties every year. When I went through the snowstorms in January—and we got stopped sometimes by the snow—at every location there were bigger crowds than I have ever seen, and the difference was this issue.

These were not, as the Senator from Maine indicated, people who were making a lot of money off of this. These are hard-working people in rural areas, county people, nonprofits, who are just trying to do their job.

The Director of the Price County, WAS health department, which is pretty far up in Wisconsin, serves about 115 Medicare home health care clients per year, and they contacted me to say that IPS would result in a 25 percent reduction in their Medicare reimbursements.

In Western Wisconsin, the Director of the LaCrosse County health department, which serves 107 Medicare home health clients per year, contacted me to say that they'll experience a shortfall of more than 40 percent. These dramatic reductions in Medicare home health care reimbursement are truly devastating for these not-for-profit entities who serve rural areas. I am deeply concerned, as we all are, about these reductions.

Mr. Chairman, I look forward to this hearing, and again, thank you sincerely for hitting the right buttons for this committee.

The CHAIRMAN. Thank you, Senator Feingold.

Senate Hagel.

Senator HAGEL. Thank you, Mr. Chairman, and thank you for focusing the attention of this committee on this very important issue.

I have a statement that I will submit for the record, Mr. Chairman. That being the case, I leave more time for my friend from Rhode Island, Senator Reed.

Thank you.

[The prepared statement of Senator Hagel follows:]

CHUCK HAGEL

OPENING STATEMENT OF SENATOR HAGEL

U.S. Senate Special Committee on Aging Hearing
"Access to Care: the Impact of the Balanced Budget Act on Medicare Home Health Sevices"
March 31, 1998

Thank you, Mr. Chairman. Thank you for calling this important hearing of the Senate Special Committee on Aging.

The home health care benefit is a key part of the Medicare program. By allowing seniors to receive care in their own homes, as opposed to hospitals or nursing homes, we help them stay independent and fully connected with their families and friends. This generally leads to happier, healthier beneficiaries. Home health care also makes good business sense for the Medicare program by avoiding the higher costs associated with receiving nursing care in an institutional setting.

Home health care has also been one of the fastest growing areas of Medicare spending. Spending has increased from $2.5 billion in 1989 to $18.1 billion in 1996, for an average annual growth rate of 33 percent. That's why last year's Balanced Budget Act contained provisions that were intended to slow the growth of spending in home health care and also protect beneficiaries and taxpayers from waste, fraud and abuse.

However, it is unclear whether these reforms are having the intended effect. In many instances, these provisions seem to penalize honest, low-cost agencies and deserving beneficiaries — especially those in rural areas. This has been our experience in Nebraska.

This morning we will focus on three issues relating to Medicare home health care — the new interim payment system (IPS), changes to the the blood draw benefit, and the new surety bond requirement. IPS limits the amount of money that Medicare will reimburse a home health agency for an individual patient. Nebraska's providers are concerned that the way in which these payment limits are determined punishes cost-effective agencies, rewards wasteful agencies, and creates a perverse incentive to avoid sicker patients.

The drawing of blood (or venipuncture) alone no longer qualifies as a "skilled" service under Medicare. This means those individuals needing blood draws will only receive full home health care services if they also qualify for a "skilled" health care service. Medicare will still pay for a lab technician to travel to a beneficiary's home and draw blood. However, Nebraska's seniors have experienced confusion and difficulty in finding providers to perform this service.

Home health agencies are now required to obtain surety bonds as a condition of continuing participation in Medicare. The Health Care Financing Administration (HCFA) has proposed regulations that would allow these surety bonds to be used for the recovery of Medicare overpayments to home health agencies. While agencies of all sizes have had trouble meeting this new requirement, this is of special concern to Nebraska's smaller, rural agencies, since they

typically do not accumulate assets sufficient to secure a $50,000 bond.

We all want the same thing — to preserve the Medicare home health care benefit for those truly in need of these services. We need to achieve this goal in a way that rewards providers who play by the rules and punishes those who don't. If we work together on this and other Medicare issues, we will find solutions that preserve this valuable program for generations to come.

Today's hearing is an important step in the right direction.

Thank you, Mr. Chairman.

STATEMENT OF SENATOR JACK REED

Senator REED. Thank you, Senator Hagel, and thank you, Mr. Chairman. I want to commend the chairman for holding this hearing on a very important topic.

We all understand that the Medicare home health benefit plays an increasingly important role in the lives of our seniors. We also understand that over the last several years spending on this particular provision has increased dramatically. As a result, we implemented changes in the Balanced Budget Act, intended to curb this cost, but certainly not intended to take away from needy seniors this very, very important benefit.

Today I'm pleased that we're looking at some of the aspects of these changes—the interim payment system, the surety bond requirement, and other aspects. And we're doing so with a concern that our intended savings do not translate into unintended losses to seniors.

I would like to associate myself with the remarks of my colleague from Maine, Senator Collins, with respect to the impact in New England. I would once again refer to the article which she pointed out from the Wall Street Journal, that because of our heritage of not-for-profit health care, we have been disadvantaged by the rules that are proposed in terms of the payment schemes and the proposals that are now on the table. This is something that is of great concern to both her and I, and I would look forward to working with her on this issue.

We are concerned, all of us, about the long-term impact of the legislation and the proposed changes, and I look forward to working with all of my colleagues to ensure that not only do we save resources but we continue to support seniors, keep them in their homes, and keep them available for these benefits. I hope we can do that.

I thank the chairman.

The CHAIRMAN. Thank you.

Senator Baucus, I have already recognized you for your work on the rural health caucus, but also you've been working with us in our coalition to bring this to the attention of HCFA as well. So you can speak now.

STATEMENT OF SENATOR MAX BAUCUS

Senator BAUCUS. Mr. Chairman, thank you very much for the opportunity to speak, and I thank the other members of the committee for their indulgence.

I want to underline the points that other members of this committee have made about you. You are a very——

The CHAIRMAN. Keep talking. [Laughter.]

Senator BAUCUS [continuing]. A very solid, focused Senator on issues that count, on issues that matter, whether they're rural or aging or health care. Our service together on the Finance Committee has given me the opportunity to watch and observe and work with you, Mr. Chairman, and as I visit you on this committee, I see the same Senator at work and commend you for what you're doing.

The CHAIRMAN. Thank you.

Senator BAUCUS. Mr. Chairman, I have a written statement which I would ask to be included.

The CHAIRMAN. We will include it in the record.

Senator BAUCUS. Just a very simple point I would like to make, and that is, first to echo the statements that have been made, namely, the big increase in home health care costs under Part A. In our attempt to rein them in reasonably, we perhaps went overboard, and our efforts here now are to try to correct those mistakes.

In my State of Montana—and let me just give you one example that will give you a sense of the problem—we have about 60 home health care agencies. These are agencies which don't mind—they don't like it—but don't mind as much the surety bond requirement with respect to Medicare. But these are also agencies that serve both Medicare and private pay patients, and often very few Medicaid patients. So the requirement of an additional surety bond for Medicaid patients in addition to Medicare patients means that the total surety requirement will cost more in dollars than dollars that are paid out of Medicaid to patients in home health care. That is, if you multiply the 60 agencies times the bond requirement on one side, and offset that with the number of dollars they are paid under Medicaid to low-income patients under home health care, the bonding requirement is greater than the dollars that go out, which doesn't make a lot of sense.

So I would like all of us, Mr. Chairman, to work to solve that problem, as well as the interim payment question, which has been mentioned several times here, and on top of that, I would be interested to hear from HCFA Administrator Nancy-Ann Min DeParle about the automatic 15 percent reduction of home health care payments intended for October of 1999.

Again, thank you, Mr. Chairman, for your holding this hearing. It's very much needed and I look forward to working very much with you, the HCFA Administrator, and others as we work this out.

[The prepared statement of Senator Baucus follows along with prepared statements from Senators Craig, Kohl, Enzi, and Jeffords:]

Statement of Senator Max Baucus
Changes to Home Health Care in Medicare
Senate Aging Committee
March 31, 1998

Thank you, Mr. Chairman, for inviting me to today's hearing on implementing the home health provisions of the Balanced Budget Act. You and I have been working on these issues for a long, long time. I appreciate you extending me the honor of participating in today's Aging Committee hearing.

Mr. Chairman, let me say from the start that the problems we will be talking about today are the fault of Congress. We passed these provisions last year to rein in Medicare spending on home health care, and the changes are causing some pain.

However, I stand by the goals of the Balanced Budget Act. During the first 15 years of the Medicare program, home health spending accounted for 1 to 2 percent of all Part A expenditures.

In 1997, home health expenditures reached 14% of Part A payments. Certainly, Congress needed to respond to this growth. And we did.

But there are some provisions in the Balanced Budget Act of 1997 that Congress may need to rethink. And there are other provisions that I support, but I believe are being implemented incorrectly.

We don't need to undergo a drastic overhaul to fix these problems. I'm talking about a minor tune-up.

Let me give one brief example of problem in the new law. The Balanced Budget Act requires a minimum $50,000 bond for home health agencies to do business with Medicare. This is a requirement that I support.

But the law also requires agencies who take Medicaid patients to buy another $50,000 bond. At first blush, this makes sense.

Looking at my home state of Montana, however, the $50,000 Medicaid bonding

(More)

requirement is extremely onerous. There are several agencies that primarily see Medicare and private pay patients, and only a handful of people on Medicaid.

These agencies have already told me they do not plan to buy a $50,000 bond to serve, say, seven Medicaid patients. In states like Montana that have a Certificate of Need requirement, this means low-income people will lose access to home health care.

Just to show how much a problem the Medicaid requirement is in Montana, if you add up the 60 agencies in my state, and require each of the agencies serving Medicaid patients to buy a $50,000 bond, the bond amounts are equal to the amount of Medicaid spending in Montana on home health care.

Thus, every single Medicaid home health care dollar in my state will be bonded. Certainly that is not what Congress intended when we passed the law, and I am looking at legislation to lower the $50,000 minimum for a Medicaid bond.

Mr. Chairman, I am very pleased that the Senate Aging Committee is holding this hearing today.

I am particularly interested to hear from Nancy-Ann Min Deparle, Administrator of HCFA, on a variety of issues, ranging from HCFA's plans to use surety bonds to collect overpayments, to her thoughts on the automatic 15% reduction of home health payments in October of 1999.

Thank you once again, Senator Grassley, for your invitation to participate in today's important hearing. I look forward to working with you in any way I can.

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SENATE COMMITTEE IN AGING
ACCESS TO CARE: THE IMPACT OF THE BALANCED BUDGET ACT ON MEDICARE HOME HEALTH SERVICES
STATEMENT OF LARRY E. CRAIG
MARCH 31, 1998

Mr. Chairman, thank you for holding this very important hearing today on the impact of the Balanced Budget Act on Medicare Home Health Services. The changes in home health services and billing were made in order to stabilize the Medicare program, and were necessary to balance the budget. However, some of the provisions may have unintentionally hurt beneficiaries, by hindering their access to medical care.

This hearing today will examine three important issues regarding seniors' access to home health care. Congress needs to work with the Administration in order to make home health services efficient and cost-effective. I commend the Chairman and the Ranking Member for gathering such an experienced panel of witnesses. I look forward to listening to everyone here today.

The Interim Payment System, venipuncture, and surety bonds provisions in the Balanced Budget Act were made in order to stabilize the Medicare program. Without change, Medicare would be facing

bankruptcy in less than a decade. When making these kinds of changes we need to keep in mind that balancing the overall federal budget remains critical to ensuring the preservation of Medicare.

The changes made in the BBA may have inadvertently targeted the weakest and most frail of the senior population. I am particularly concerned about those in rural settings, like my state of Idaho. I have heard from many of my constituents who are afraid of losing the important care they are currently receiving at home.

This hearing will undoubtedly be informative as to the current status and future developments of home health care. I look forward to the discussions here today. It is important that we evaluate these provisions, and look into any changes to continue providing health care to America's seniors.

Herb Kohl

Statement of Senator Herb Kohl
Senate Special Committee on Aging hearing on Home Health
Provisions in the Balanced Budget Act
March 31, 1998

Thank you, Mr. Chairman. I appreciate the opportunity that you and the Ranking Member, Senator Breaux, have given us to discuss this issue, which is of great importance to many people in my State and across the nation.

I look at this hearing as an opportunity to have an open, honest discussion about the impact the Medicare changes in the Balanced Budget Act will have on patients who receive home health services.

As everyone on today's panels know, this issue has generated a great deal of concern among both providers and patients that home health benefits will be cut off or greatly reduced. This certainly was not the intent of Congress in making these changes, nor do I believe it will be the effect of HCFA's regulation as they move to implement the law.

However, I do believe that we need to review the reasons why these changes were made in the first place. We have heard these statistics before -- home health has been the fastest growing component of Medicare, with an average annual growth rate of 32% since 1989. The average number of home health visits per beneficiary has doubled, and in some cases, tripled. We all know about the studies done in several States, indicating that there is a significant problem of inappropriate and fraudulent Medicare payments for home health services. With Medicare's financial problems, it was vital that we bring spending under control.

However, despite these problems, I also know that home health care can often provide a better, more cost-effective way to deliver care to patients. Home care allows patients to stay in their homes where they are often more comfortable, and helps reduce the high costs of institutional care.

In my home state of Wisconsin, we have unusually low utilization and low costs in home health care. I am concerned about the impact that the BBA changes may have on access to home health services in my State and others like it, where the vast majority of our providers have done a tremendous job. I hope the panels will address this important issue today.

Beyond the changes in the BBA and today's discussion, I also think we eventually need to take a look at the future of home care and its place in the Medicare program. We all know that the Medicare home health benefit was not originally intended to be a long-term care benefit. Part of the reason that we find ourselves in this predicament today is because the Medicare home health benefit has grown so quickly and the Medicare program itself was not equipped to handle this growth.

However, it is clear that in many cases, home care is far more preferable and cost-effective than institutional care. As the Medicare Commission and eventually, Congress, consider long-term reforms of Medicare, I believe we must consider whether and how we want Medicare to treat long-term care needs, and how home care could fit into that scenario. I realize that these are issues for another hearing, and probably many hearings. But I believe that by focusing on them when we consider future Medicare reforms, we will reduce the need to have discussions like the one we are having today.

The issues we will discuss today are not simple and do not have the same implications for every State or beneficiary. In

those areas where we can go back and improve the BBA provisions, or encourage HCFA to do so, I believe we should -- however, we must keep in mind the original intent of these changes and the costs associated with any revisions. We will not solve all of these issues today, but I am glad we are beginning this dialogue.

Above all, I think it is vital that as we implement the changes in the BBA, we make sure that these changes do not reverse the positive benefits of home care, drive legitimate providers out of business, or make home care inaccessible to people who truly need it.

Again, I thank you, Mr. Chairman, for the opportunity to focus on this issue. I look forward to hearing from today's witnesses as we talk frankly and honestly about the impact these home health changes will have for patients, providers, and for the Medicare program.

Senate Aging Committee Hearing on the Impact of the Balanced Budget Act on Medicare Home Health Services
Statement by Senator Michael B. Enzi
March 31, 1998

Thank you Mr. Chairman for holding this important hearing to review the effects of the recently enacted Balanced Budget Act on Medicare's home health services. As we are all aware, there has been a great deal of attention focused on Medicare's home health services in the last year. Home health care is one of the fastest growing categories of Medicare expenditures. In fact, home health care reimbursements have grown from $3.7 billion in 1990 to $16.7 billion in 1996, which is a significant increase in just a 5 year span. Recent reports and congressional hearings have highlighted the extent to which fraud and abuse is plaguing the system. Unfortunately, this has resulted in a one-size-fits-all approach by the Clinton Administration to crack down on fraud and abuse in the home health industry. While it is important that all fraud and abuse in Medicare be addressed, it is equally important to ensure that small businesses that operate honestly and efficiently within the home health industry are not burdened by excessive requirements intended to

weed out only the unscrupulous home health agencies.

I am particularly concerned that the Health Care Financing Administration (HCFA) has exceeded congressional intent in implementing the surety bond provision of the BBA. The BBA mandated that home health agencies post a $50,000 surety bond in order to participate in the Medicare and Medicaid programs. This provision was intended to harness the expertise of private insurance companies in evaluating the viability of home health agencies. The private insurance companies guaranteeing the surety bonds would only offer them to legitimate business enterprises, thereby driving the fly-by-night agencies out of business. Unfortunately, HCFA has also required that the bonds be used to reimburse them for any overpayments to home health agencies whether they were accidental or the result of fraud. This has made the bonds prohibitively expensive for many of the smaller home health agencies.

The unfortunate result of this regulation, as it is currently drafted, would be to drive many legitimate home health agencies out of business. Wyoming has about 60 home health agencies and they are having an

extremely difficult time in obtaining the surety bonds. Home health agencies operate very differently in rural states like Wyoming than in states like Florida and California. Our home health agencies are much smaller and more community-oriented. They simply do not have the assets that are necessary to obtain a surety bond under HCFA's regulations. As a result, many of the small businesses will be forced to go out of business and our senior citizens will no longer have access to necessary health care services. This would have disastrous effects in Wyoming, where home health care agencies are essential in providing health care across our sparsely populated state.

I understand the Chairman is working with HCFA to change the nature of the surety bond regulation by dropping the overpayment provision. I certainly support the Chairman in this effort. If HCFA remains intransigent, however, we will have to consider alternative approaches to deal with this problem, such as allowing states to financially guarantee the surety bonds. We must explore all avenues to ensure that HCFA's implementation of the surety bond law does not result in the ruin of many small businesses nor reduce the availability of health care to those who need it.

Once again, I commend the Chairman for holding this hearing. Medicare fraud and abuse is certainly a problem that needs to be addressed as Congress continues its struggle to restore solvency to the program. However, these efforts need to be targeted towards those who are abusing the system, not applied in a one-size-fits-all manner that unnecessarily burdens legitimate businesses. It is also important that we do not reduce the affordability and availability of health care for our nation's senior citizens. I will be working to ensure that Wyoming's small home health agencies and Medicare beneficiaries are treated in a fair and practical manner as we continue to combat all fraud and abuse in the Medicare program.

PREPARED STATEMENT OF SENATOR JAMES M. JEFFORDS

In announcing this hearing, Senators Grassley and Breaux correctly stated that it was the intent of the Balanced Budget Act of 1997 (BBA) to ensure that the Medicare system will be available for current and future generations of Americans. I want to thank Senators Grassley and Breaux for holding this important hearing so that we may learn about the unintended consequences of the Balanced Budget Act.

I have learned that certain BBA provisions present serious problems to home health agencies in my home state of Vermont. For months I have received letters, phone calls, and personal visits from concerned citizens and anxious agency directors, in addition to correspondence from public officials and state administrators. The outcry has been persistent and the message consistent. The problems are having an immediate impact and there are serious consequences on the survival of Vermont's home health agencies.

I have heard from each and every one of the thirteen home health agencies in Vermont, all of which are non-profit organizations. Collectively, they are proud to be the state with the lowest cost-per-beneficiary in the country in the Medicare program. They have worked hard to be prudent and efficient in the provision of service. They are understandably concerned that they are being punished for their well-intentioned efforts. It is critical that Congress take measures to thwart those who squander and misappropriate public resources for their own personal gain. But our most important responsibility is to be sure that these measures do not cause harm to those who provide and benefit from home health services.

Given the unfairness of a payment system that penalizes Vermont's efficiency, I have been in close contact with the office of the Administrator of the Health Care Financing Administration, Nancy Ann Min DeParle, and I am anxious to hear her assessment of the situation here today. In addition, I and Senator Leahy of Vermont recently joined with others in introducing legislation designed to postpone implementation of the interim payment system and continue to investigate options for making improvements to the interim system. I assure you, preserving the valuable services of Vermont's home care providers is a high priority with me.

In closing, I want to note my belief that the concerns being raised about home health care services are evidence of a more fundamental problem about the provision of long term care. Medical science is giving our aging population the ability to survive acute health crises. However, as a group, we will be living longer with chronic illnesses. The Medicare program was designed as an acute care program. The growth in home care and accompanying financial impacts are driven, not by acute, but by chronic illnesses. I urge the Bipartisan Commission on the Future of Medicare, chaired by our able colleague, Senator Breaux, to give high priority to its mandate to examine the chronic health care needs of beneficiaries. While this hearing may address short term issues, for the long term we need to update Medicare to address the need for chronic care in ways that are appropriate and affordable.

The CHAIRMAN. Before my colleagues take off, I wonder if we could give the courtesy to the Administrator, Nancy-Ann Min DeParle, to listen to her for 6 or 7 minutes. We will still have time to go vote. Then I will break at the end of her testimony.

I won't even bother to introduce you. Would you please go right into your testimony.

STATEMENT OF NANCY-ANN MIN DEPARLE, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Ms. DEPARLE. Thank you, Mr. Chairman. I think 6 or 7 minutes ought to be ample time.

The CHAIRMAN. You bet.

Ms. DEPARLE. Thank you for convening this hearing today to talk about our progress in implementing the Balanced Budget Act changes to strengthen and preserve Medicare's home health benefit.

As everyone here has said, the home health benefit is important to the 4 million Medicare beneficiaries who receive these services that improve their quality of life and enable them to recuperate at home.

The majority of home health agencies serving Medicare are honest and provide good care. I think we've heard a lot of that this morning.

Unfortunately, as this committee has noted this morning, home health spending has grown at an unsustainable rate, with increases averaging more than 25 percent per year from 1990 to 1997. Home health spending has been one of the fastest growing components of Medicare. In 1990, Medicare spent 7 billion on home health, representing about 3 percent of Medicare payments, but by 1997, home health payments had grown to 20 billion, almost 10 percent of total Medicare spending. And average visits per beneficiary had more than doubled from 33 to 78.

There has been far too much waste, fraud and abuse. The Inspector General and the General Accounting Office have submitted several studies to the Congress and to HCFA which detail these problems, showing that as many as 40 percent of the claims in home health should not have been paid. So we had a problem to deal with.

At the same time, Mr. Chairman, as you know, our resources to audit agencies and to review claims have been shrinking over the years. In this year's budget, we're requesting additional funds to increase our audits and reviews and surveys to make sure that the taxpayers' dollars are spent only on services that meet the law's requirement. I look forward to working with all of you to enact these provisions.

Today's hearing focuses on the Balanced Budget Act provisions that address the problems of unsustainable growth and waste, fraud and abuse. I believe the reforms that we're making are critical to preserving the Medicare home health benefit in the years to come. But with major reforms that generate nearly 17 billion in home health savings over 5 years, even the most efficient agencies must become more efficient.

We have heard concerns from home health agencies, too, just as you have. I have been out around the country, and also I have met with agencies here in Washington. We recognize the challenges that these changes present for home health providers, and we want to work closely with the industry and with Congress as we implement them.

Medicare is moving to a prospective payment system that for the first time creates incentives for home health agencies to be efficient, and everyone, the Congress, the Administration, and the home health industry, agrees that this change is necessary. Under the prospective payment system, the incentive to supply virtually unlimited visits will be eliminated, and also, Senator Collins, some of the things that you have talked about and that Senator Reed talked about, and geographic disparities, will be dealt with by this prospective payment system.

As we work on an ambitious schedule to develop and implement a prospective payment system for home health, we are implementing the interim payment system required by the Balanced Budget Act to help control costs in the short term.

There is a lot of misunderstanding around the country about what this new interim payment system does and what it does not do. It does reduce payments to home health agencies in the aggre-

gate by producing 1.6 billion in savings during fiscal year 1998. But contrary to what you may have heard, it does not cap the number of visits any one patient may receive, nor does it limit the amount of money that can be spent on any one patient.

The law does create incentives to scale back utilization to fiscal year 1994 levels and on average, across the country, that would be a reduction of about 12 visits per year, from 78 to 66, or one visit per patient per month. Of course, for any one agency—and those are the agencies that you're probably hearing from—for some of them it might be more than that. These are aggregate numbers.

Setting a budget for home health agencies does not have to compromise care. It requires agencies, though, to provide appropriate care that physicians prescribe in a financially responsible manner.

Another misunderstanding involves the closing of a loophole that allowed beneficiaries who only needed their blood drawn to receive virtually unlimited personal services, such as help with bathing. In Operation Restore Trust, our antifraud and abuse initiative with the Inspector General, we found many instances where this loophole was being abused. In one case, a patient who needed no skilled treatment was receiving skilled nursing services once or twice each week, and a home health aide was ordered for 12 hours a day, 7 days a week, to assist in showering, meal preparation, shopping, laundry, housekeeping, safety supervision, and escorting.

As you know, Mr. Chairman, the Social Security Act specifies that personal care services can be covered only when directly related to skilled treatment of an illness or injury. The venipuncture loophole was clearly contrary to the spirit of the law. Under the Balanced Budget Act, Medicare still pays for blood draws at home, but under Part B rather than under the home health benefit. We are reviewing whether we need to raise the amount paid for travel to beneficiaries' homes for blood draws and, if changes are needed, we'll make them.

We are also addressing some technical issues in the regulation that we published in January implementing the new surety bond requirement. We hope that surety bonds will help weed out agencies that should not be billing us and help us recover taxpayers' money that should never have left the trust funds.

On that point, I want to note that it has been especially hard to get money back from home health agencies. Half of the overpayments that Medicare is unable to collect are from home health agencies. Recognizing this problem, the Inspector General recommended in 1996 that we require agencies to post bonds equal to 100 percent of their previous year's Medicare reimbursement. But, in implementing the Balanced Budget Act requirement, Mr. Chairman, we set the requirement at 15 percent, which we thought was reasonable, since it wouldn't be too high so as to be a barrier for small agencies but high enough to provide the trust fund with a reasonable ability to recover the debts that are owed to Medicare.

The average Medicare reimbursement to home health agencies last year was around 1.6 million, so the average agency needs a bond of about $250,000. We understand that these kind of bonds cost agencies about 1.5 percent of their face value, so the average agency is getting a bond for around $4,000.

I want to report to you today, too, that more than a third of the home health agencies in the country have already received bonds. Around 25 percent of them are small agencies, with annual Medicare reimbursements of less than $200,000. Another 25 percent are what we would call medium-sized agencies that have annual Medicare reimbursements between $200,000 and one million dollars. Half of the agencies that have received bonds already are large agencies with annual Medicare reimbursements that are above one million dollars.

We currently have around 11,000 home health agencies serving four million Medicare beneficiaries, and the number of agencies has been growing about 20 percent a year, and in some of your States, even more than that. Based on Florida's experience, I would expect that the surety bond requirement probably will deter some agencies from entering the business. Florida, as you know, pioneered the use of surety bonds for home health providers in Medicaid, and they believe—and I've spoken with the officials down there—they believe that the bonds achieved their objective by weeding out some of the unscrupulous providers.

But as you know, we're also revising the regulation to clarify some technical issues, such as the limits of liability. We have also extended the time by which agencies must comply to 60 days after publication of the final rule. We believe that once this regulation is published, most agencies will be able to obtain bonds.

All of these changes, we believe, help strengthen and preserve Medicare's home health benefit. But I want to emphasize, Mr. Chairman, that I recognize that these changes are difficult for the provider community. Home health agencies are being asked to change their past behavior, to plan and deliver care more efficiently, when in the past they basically just relied on whatever their actual costs were, and they're being required to bill Medicare only for the services covered under the law.

Congress and the Administration are requiring agencies to be better managers of the taxpayers' money. We believe that the majority of our Medicare home health agencies can and will meet these challenges. But I look forward to working with the committee as we implement the Balanced Budget Act and enacting also the President's fiscal year 1999 proposals.

I would be happy to answer any questions that the committee has.

The CHAIRMAN. I'm going to call a recess for about 7 or 8 minutes.

Ms. DEPARLE. Thank you. [Recess.]

The CHAIRMAN. Thank you very much, Ms. DeParle, for your testimony, and your willingness that you expressed in your statement to work with those of us in Congress trying to find a solution.

Some of my questions will be directed towards the direction that you would like to go, or you think we should go, and even some indication of what yo' think Congress should do. Let me suggest to you that we tend to always blame the administrator, or somebody in the bureaucracy, but in this particular instance, I think we can confess for all of Congress that we were focused on the prospective payment system for the future way of paying and maybe didn't focus enough on the interim payment system. Of course, you were

not even in your position when we adopted this, so you get all this thrown in your lap.

I want to say that maybe Congress bears some responsibility, even though we were responding to the initiative of HCFA on the prospective reimbursement and the other issues as well, that perhaps we did not look into them deep enough. I'm talking about the interim payment system. I think we adequately thought through the prospective reimbursement system for the long term.

So, as I indicated, you were not in this position when Congress adopted it and when HCFA made the recommendations, so maybe you bring a fresh perspective to it, helping us to solve our problems.

My first question is in regard to the interim payment system. You have heard it indicated by all the members here of how it punishes low-cost agencies, while rewarding high-cost agencies.

First of all—and I'll ask three or four questions right at once because they all hook together—your response to this criticism, if you agree with the criticism. Do you believe Congress should act this year to change the interim payment system and, if so, is your agency willing to propose changes, or maybe better yet, to work with us and the Finance Committee intensively in the next few weeks in order to accomplish these changes during this session of Congress?

Ms. DEPARLE. Well, Mr. Chairman, I have certainly heard the criticism that the new interim payment system punishes the lower-cost agencies. I must admit, I have looked specifically at your State of Iowa, and the average payment per user there is much lower than other areas of the country.

Now, what that means is those agencies, in general, the kinds of reductions they will have to make will be less because they have been more efficient. But, on the other hand, some of them would argue—and I've seen some testimony from some of the folks from Iowa today—perhaps that they shouldn't have been hit at all, and they are affected by the interim payment system. So I can certainly see their point of view.

I do want to point out, though, that some agencies should actually receive higher payments under this new system than they have in the past, and the reason is that we're blending under the statute the agency's own cost for 1994 with a regional number for 1994. There are some agencies—and I suspect there will be some in your area, in your region, your State—that have had lower costs than other agencies in the region, so they might, in fact, receive slightly higher payments than they would have under the old system.

But there is no question that some agencies have had higher utilization, have had more excessive growth than others, and the interim payment system does affect all of them.

I guess I would just say that the interim payment system, while perhaps it was not debated as much as the prospective payment system—and as you say, everyone agrees that that's where we want to be in the end—the interim payment system was intensively analyzed and worked on for 2 or 3 years, starting with, I guess, when it was first proposed in the summer of 1995. I think a number of different ways of doing this were looked at over the

intervening period. My understanding was that it was not possible to come up with something that everyone felt was fair and that would also achieve the objective of reducing the rate of growth, so this is what Congress in the end settled with.

We, of course, will always work with you to provide technical assistance and to give you an analysis of how different systems might affect agencies across the country and in the States, and we would be happy to work with you.

As you know, right now we have been concentrating on implementing this new system, so that is where our work has focused.

The CHAIRMAN. I presume, then, your answer at this point is that you're willing to work with us but you would not, yourself, or your agency, propose changes; is that what you're saying?

Ms. DEPARLE. I think that's right, Mr. Chairman.

The CHAIRMAN. Let me explore with you then some follow up. A few of us on the Finance Committee, as has been indicated by several of us who spoke this morning, are exploring different approaches to the per-beneficiary limit concept. Some of them involve reducing or eliminating the reliance on each agency's historical costs, instead using basing the formula on some mix of national and regional averages. In addition to providing different incentives, this would seem to be much simpler administratively than the current system.

What are your thoughts on that approach, assuming that it's done in a budget-neutral way?

Ms. DEPARLE. Well, I heard about this approach yesterday, and I think it's intriguing. I guess I would say that you will be reopening the debate, and certainly it's a legitimate debate, about how much difference there should be around the country in these per-beneficiary costs.

As I pointed out, in looking at Iowa, your agencies' average payment per user in Iowa is less than $2,500. There are other States, including the one where I'm from, where it's up to $5–6,000. When we analyze that and look at things like health status and other reasons why that would be the case, it is hard to justify. I'm glad, as I think you are, that we're moving to prospective payment which will certainly mitigate that.

We would want to work with you and look at how administratively feasible such a new proposal might be. In other words, we are now in the middle of implementing this system that's supposed to save, I guess 1.6 billion for this year. To implement that system, you instructed us to use data from agencies for 1994, so we would want to be sure we could use the same data, if you want to get this implemented quickly. But we would be open to looking at with you and working with you on it.

The CHAIRMAN. I understand part of the rationale for relying on agency-specific historical costs rather than the more uniform payment was to avoid disruption of the system. The concern was that high-cost agencies couldn't make such a major adjustment so fast.

But won't these same agencies have to make that adjustment as soon as the prospective payment system is put into place next year anyway? Doesn't it make more sense to have an interim system that is a step towards the prospective payment system, in terms of

more uniform payment for all agencies, rather than one that looks backwards?

Ms. DEPARLE. Well, Mr. Chairman, I think that the interim payment system is a step towards the prospective payment system. It is not as large a step as what you have just talked about, which would base more of the payment on a formula that would involve focusing on national costs rather than agency specific, actual costs. So it is a step in that direction. It's not as big a step in that direction.

I think the issue that people looked at in implementing this, when they were considering the Balanced Budget Act, is how much of a transition do agencies need. I think that's the issue.

The CHAIRMAN. Senator Reed, and then I'll call on Senator Burns and Senator Santorum. Senator Reed, go ahead.

Senator REED. Thank you very much for your testimony.

Once again, following up on my comments initially—and I'm sure you have already commented on them yourself—it seems unfair that agencies in certain areas of the country, particularly agencies in Rhode Island, would be punished, in effect, because they've been efficient and haven't had incidents of fraud and abuse to any significant degree, and yet they're the ones who are going to be faced with very, very difficult ceilings in terms of their reimbursements.

I wonder what you can do, or what you propose to do—and maybe I'm replowing old ground—but what you can do to change the present situation.

Ms. DEPARLE. Yes, Senator, I did say in response to a question from the Chairman that I am concerned about the criticism that this system unfairly affects agencies that have been more efficient. I would point out, though, as I pointed out in response to him, that the agencies that have been more efficient in a sense will have to reduce less to come into compliance with the new caps. Some of them have probably argued to you that they don't think they should be affected at all, but they are affected less than some of the agencies that have spent at much higher and unsustainable rates that will have to come down more.

It is difficult to say what can be done about it at this point. We're in the process of implementing a new interim payment system which achieves savings for the Medicare program. This was analyzed for several years by a lot of smart people, who saw how difficult it was to come up with something that agencies would regard as fair, that we could implement in a way that was relatively equitable and tried not to disrupt the current system too much. It's very difficult to do, and I think that's what we're seeing now.

As I told the Chairman, we're always open to providing you with technical assistance. If you want to see how different proposals would affect Rhode Island, I would be happy to try to get you that information.

Senator REED. Have you, or has anyone in your agency, looked at the collateral impact on the States, the fact that their Medicaid budgets will increase, the fact that other spending—I know in my home State of Rhode Island, our Department of Elderly Affairs has other programs that try to keep people in their homes, that complement what the home health care benefit from Medicare provides.

I'm wondering if you have any information about the overall impact.

Ms. DEPARLE. I don't have information on that at this point, but I think you raise a good question. Senator Shelby is not here now, but I think in particular he has raised a number of questions with me about the venipuncture provision, which does appear to have affected particularly the Southern States.

The difference that I've been able to determine is that, in some States, such as Rhode Island and some of the New England States, there are other systems in place, through Medicaid or through other community or State funding, to provide services for people who might not qualify under Medicare. So I would expect in some of those States that you will see some increased costs. I don't have any information on that at this time, but I would be happy to try to monitor it and get back to the committee, because I think that's a good question.

Senator REED. It seems to me—and again, we're kind of parsing the same sort of sentence, left and right in different ways. But it seems to me that we're missing the overall strategic objective, too. A lot of home health care was promoted initially to save money by getting elderly sick individuals out of hospitals, out of expensive nursing homes, into the home. Then we saw that price go up dramatically to our Federal budget and we started ratcheting back dramatically.

But have you thought in a broader sense, that perhaps this is not the most efficient way to deal with this problem, that, in fact, it looks like we're spending a lot of money on home health care but, if you look at the alternatives, with increased nursing home payments through Medicaid, increased hospitalizations through Medicare, that, in fact, this may be a wise thing to do—maybe not exactly the old fashioned way, but certainly not the kind of constraints we're putting on now.

Do you have any analysis like that?

Ms. DEPARLE. We have done some analyses like that, Senator, and I would be happy to share it with you. That was a question that I asked myself, because I do think that home health care is important as a support system for people who, as you point out, we wanted to be in less expensive forms of care. That's what the prospective payment system for hospitals was all about.

But in looking at it, it appears, based on the data that I've seen, that even if you take into account the fact that we wanted people to move to less expensive forms of care and less acute care, that there has still been an increment of growth that is not related to that, and not related to health status.

The issue is whether 30 percent growth per year was sustainable for the Medicare program. I think that's what people have been wrestling with for the past few years, which is why these Balanced Budget Act provisions came into being. But I would be happy to work with you, to continue to look at that question, because I think it's a good issue.

Senator REED. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Before Senator Burns proceeds to his questioning, I wanted to tell Senator Burns, Senator Santorum and Senator

Breaux that we've had more of a turnout of this committee—and even some noncommittee members have come to make opening statements—than almost any hearing we've had, which I think highlights the significance of the problem we're dealing with. Hopefully, it will be a visible image of our concern about getting it fixed.

Senator Burns.

Senator Burns. Thank you very much, Mr. Chairman.

I think the reason for that is because we all believe very strongly that home health care has a very important role to play, as far as caring for our elderly and keeping them in their homes as long as we possibly can.

They have already asked you the questions that I had down here, and there's no use being redundant about that.

I am still concerned about the surety bonds. I know something about bonding. I had to have a bond to do business before I came to the Senate. I still have that bond.

Is there anything being done about—Even though you might do business in two States, a home health care agency that may be doing business in two States, and they're required to carry two different bonds, is that being looked into and taken care of?

Ms. DEPARLE. Yes. The issue that your colleague from Montana raised, actually before the recess, was the concern about having to have a bond for both Medicare and Medicaid, which the Balanced Budget Act does require.

One of the things I'm looking at is, is whether there is a way to require only one bond, so that agencies don't have to go through having more than one, and as you say, if they do business in more than one State. I don't know whether that's possible or not. What I would like to do is try to get to the bottom of it and get back to the committee. It may be that some change is needed in order to effectuate that. But I understand your concern.

Senator BURNS. It looks like you go to, rather than a surety bond, it's going to go to a fidelity bond, because basically, it is to protect you, right, and also to protect the patient?

Ms. DEPARLE. I believe, sir, that it was supposed to have two intents. One reason why we have so many home health care agencies is that there have not been very strict standards for getting into the business. That was one message that we got loud and clear. Senator Collins has chaired a hearing on this issue, with the number of problems it has caused. So that was one reason, to deter some of the unscrupulous providers from coming into the business or from being in there.

The other one was, yes, sir, to protect the Medicare program. As I said in my opening statement, about 50 percent of the overpayments in home health we are unable to collect are in home health. So the idea would be to help Medicare be able to collect those. That's exactly right.

Senator BURNS. The bond we carried always guaranteed the checks, but I always find that I could go down the road and go way over my bond limit. I could do that before noon tomorrow. So I think the only real purpose of the bond should be that it at least gives your agency the ability to audit. I think that's the way you should approach it. I think the bond, as far as protecting you and your payment, has very, very little effect, as far as separating the

good and the bad operators. But it should be used as a tool for your auditors when you audit the agency.

The way we're set up here, out in our part of the world we have quite a bit of dirt between light bulbs. [Laughter.]

Ms. DEPARLE. I've been in your part of the world. It's one of my favorite places.

Senator BURNS. Well, just visit, and then move right along. [Laughter.]

Spend your money and move right along.

Ms. DEPARLE. I've done that.

Senator BURNS. But it's getting a little crowded, although it wouldn't seem like with 800,000 people in 148,000 square miles you would feel all that closed in.

But nonetheless, with that, you're going to put some of my people out of business with the bonding requirements as they are today. I'm very much concerned about that. And they are good operators, with a good history, and can qualify for a lesser bond. But I think the bond should be used as a tool for you to audit. That's what we ought to be doing more than anything else.

So I'll just put my statement in. I want to thank you for looking at that. If it's going to require legislation, I wish you would tell us so, so that we might make those adjustments, because I think there is support for that.

Ms. DEPARLE. If I could just clarify, too, Senator Burns, I thought you were asking about the interaction between Medicare and Medicaid bonds, both of which are required. But if an agency works in more than one State for Medicare, they only have to have one bond. It's either $50,000 or 15 percent of their Medicare reimbursement.

Senator BURNS. Why do they need it for two different agencies? Why do you need a separate bond for two different agencies?

The CHAIRMAN. You mean for two separate programs?

Senator BURNS. Yeah.

The CHAIRMAN. Medicare and Medicaid.

Senator BURNS. Yeah.

Ms. DEPARLE. The Balanced Budget Act says that both for Medicare and Medicaid they must have a bond. As I said, what I'm looking at is, whether there is a way to interpret the statute so they only have to have one. I think we're on the same wavelength and I'm trying to get to the bottom of that with our General Counsel, frankly, on whether we can do that. If we can, that's great. If not, I'll be back to you to discuss it. Senator Baucus also raised that question.

Senator BURNS. OK. Because I only had to carry one bond. You've got a dealer's bond and you've got an auction bond.

The CHAIRMAN. We will hear testimony a little bit later that would raise a question about whether two separate bonds are necessary.

Senator BURNS. I don't think they are.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Santorum.

Senator SANTORUM. Thank you, Mr. Chairman.

I came in and I did not hear your testimony, but I did hear your response to some of the questions that I wanted to hear your testi-

mony about, if you will. I must admit, I'm a little disturbed by what I hear. Maybe I'm not surprised by what I hear, but I'm disturbed by what I hear, in this respect.

What I hear you saying is, look, the balanced budget agreement requires us to get so much savings, and we have come up with a plan to get those savings. Live with it. I'm not too sure I accept that, because I think there are some real inequities in the way you came up with an interim payment system. I think other members of this committee feel the same way.

We gave you wide latitude, I understand, in the balanced budget amendment to come up with a system, but obviously, if necessary, we can come forward with some sort of legislative agenda to try to change that. That's going to be very hard to do.

I would hope that you would take from this hearing—and as the chairman said, with the extreme interest that we have at this hearing, and the number of Senators who have attended, and some of the criticisms that have been levied at this proposal—to maybe take a step back and understand that subsidizing inefficiency and waste which is what you're doing in this plan. You're spreading the risk out over everybody, whether they efficiently use resources or not. Everybody is taking the same hit. I mean, that's pretty much what you're saying, that in your terms, "not to disrupt the system."

I would suggest that if the system is abusing the taxpayer by overutilization, that's a system that should be disrupted, and to some degree, they should be disrupted more than others who, in fact, have historically had a better track record.

So I would ask the question again. Is there anything you believe you can do, given the interest expressed here, to take another look at your proposal and make some changes that I think reflect some of the concerns of this committee and Members of Congress?

Ms. DEPARLE. First of all, Senator, let me say I hope you didn't hear me the way you said, because I am concerned about this committee's views of the interim payment system and the other components of the Balanced Budget Act. I have received letters from many of you, and have met with agencies from some of your States, as a matter of fact, so I am concerned about that.

I think I need to separate two issues, though. One is the prospective payment system, which we're in the process of trying to develop. On that, yes, the Congress did give us latitude, and I expect we'll be working closely on that provision.

But on the interim payment system, after a lot of debate for several years, and a whole lot of analysis, the statute came down very specifically in what we had to do. In fact, Senator Collins has a bill that she talked about this morning for that reason, to change it, because the statute says we must use 1994 data from agencies. It says we have to blend the rates 75 percent based on the agency-specific cost and 25 percent based on regional cost.

We don't have that much latitude, I think, to correct the problem that you're concerned about, and that Senator Collins is concerned about, which is that in some States, where there have been more efficient providers, they will also be affected, even though you might argue that they shouldn't be affected and only the ones that have spent more should be affected. You're going to hear today from some of the ones in both of those kinds of States, and they

both have concerns about this. I think it is very hard to come up with something that is equitable, that will be perceived by the industry as fair, and this was where it came out.

I would also point out that there are some agencies that should do better under this system, if you can believe that. I don't think any of us have heard from them.

Senator SANTORUM. I certainly haven't.

Ms. DEPARLE. I know you haven't. I haven't, either, and I'm looking forward to that.

But there are some agencies who have been very efficient, and because these costs are being blended, based on their agency's cost and regional cost, they may, in fact, see a slight increase. But, unfortunately, as you say, we haven't heard much from them. I can't give you specifics about that today, but as the new system comes into place, what I want to do is continue to work with the members of this committee and monitor the effects of it.

Senator SANTORUM. It is my understanding, though, that HCFA played a major role in the formula being developed for the Balanced Budget Act. Is that not correct?

Ms. DEPARLE. Yes, sir, that is true.

Senator SANTORUM. Well, I guess that's where I have my problem. I do believe that the interim payment system is not a fair system, I mean, you're going to maybe have 50 percent winners and 50 percent losers under this. I don't know how it breaks out. But States such as mine, and many agencies in my State, have expressed some very, very serious concerns about their ability to go forward, not just because of the payment system but the other issues that have been brought up, the surety bonds, et cetera.

I look forward to working with Senator Collins and others to see if we can come up with a system that, in fact, rewards those who have been efficient, not at the expense of those who have been efficient.

The CHAIRMAN. I would just carry what you said one step further. It is very clear that this is a shared responsibility with Congress and HCFA. Congress went along with what HCFA recommended, so I would hope that you, as Administrator, would assume some responsibility of helping us work out a solution, a legislative solution. It has to be a legislative solution, I know. Also, even more importantly, the substance and procedure of HCFA taking that lead would help us move Congress along, I believe.

Senator Collins.

Senator COLLINS. Thank you very much, Mr. Chairman.

I do want to follow up with a couple of questions in that area. First I want to make it clear that Congress does accept its share of responsibility in this area, and we do want to work with you to come up with a solution.

What we have crafted now essentially penalizes low-cost, highly efficient, low utilization agencies, and it rewards high-cost, high utilization, inefficient agencies. Even if we are responsible for coming up with the system, whether based on your recommendations or not, we can't allow that to continue.

So my hope is that you will work with us to come up with a system that rewards those who have been frugal and careful, rather

than those agencies that have been high-cost agencies. That's my goal.

So I guess I would just ask for a commitment from you this morning to work with us. We will try to come up with legislation that is as budget-neutral as possible, but I would hope that HCFA would work with us towards that goal.

Ms. DEPARLE. Of course, we will work with you.

I also want to tell you that we'll try to monitor what's happening out there, as you are. I know you're hearing from agencies and beneficiaries, and I'm doing the same thing. So we do want to work with you.

Senator COLLINS. Thank you.

The next question I want to ask you concerns the prospective payment system, since we are talking about a problematic, interim system, but ultimately we're going to go to prospective payment, which is something the Congress supports, the administration supports, and the industry has worked on.

My concern is that there's been talk of going to a prospective payment system, I think since back in the 1980's. It certainly has been a long time coming. How confident are you that HCFA is going to be able to meet the October 1, 1999 deadline, because the interim payment system becomes even more problematic and troublesome if we're not going to meet that deadline.

Ms. DEPARLE. Yes, I understand that.

Well, I can tell you that a lot of this depends on research that is being done right now by contractors that we—that we let contracts with several years ago. We have to determine a way to adjust costs based on the risk or the health status of the people who are receiving home health services, and what is a proper episode of care and all of those things that go into figuring out how to implement a prospective payment system. They are very difficult and it's an ambitious schedule, as you know. It's probably earlier than we would have originally had liked.

Right now we are on track. So you asked me how confident I was. I would say I'm reasonably confident at this point, and the commitment I made to the chairman in the hearing we had in front of the Finance Committee was that, when it looks as though something is not on track, or it's not going to happen the way it's supposed to, I will come back to the Congress and let you know.

Right now it appears we're on track. We're waiting for some data to come in from our contractors, that's due in, I think, June or July. When that comes in, I should have a better sense of whether there's going to be a problem in meeting the deadline. At this point, I believe we will be able to meet it.

Senator COLLINS. I appreciate your keeping us informed on that. It doesn't take away from the need to reform the interim system, but I think it becomes even more pressing if we're not going to meet that deadline, so I hope you will.

Finally, I just want to turn to one other issue that's been touched on today, and that is the reimbursement for blood draws and the change in the venipuncture reimbursements. You noted in your testimony that Medicare will continue to pay for blood draws, but under Part B rather than as a home health benefit under Part A. And you've also pointed out that if a beneficiary is unable to travel

to a lab or a physician's office, Medicare will pay for a technician to travel to the beneficiary's residence to draw blood.

The problem that we're finding in my State—and I suspect it's mirrored in rural States throughout this country—is there often simply aren't the labs with technicians who can travel to beneficiaries' homes to perform these services in their areas, or they're too small and they can't afford the bond premium. There is a lot of concern that we're going to, in effect, put a very burdensome requirement of travel on the beneficiary in rural areas.

Have you looked at trying to take into account the impact on rural areas?

Ms. DEPARLE. Yes, we are looking at that. As I mentioned in my testimony, one concern I have is whether or not we are reimbursing enough for the technicians to travel. What you have raised is an even different problem that I'm not aware of, but we need to talk about that.

I am looking at how much they're reimbursed. Apparently it differs across the country. We want to make sure it's sufficient for them to be able to do the blood draws in the beneficiary's home, if that's what is needed. So I will work on that with you.

Senator COLLINS. I would appreciate that. I would encourage you to look at the availability issue in rural areas, because that's different from a reimbursement issue. Even if you're willing to up the reimbursement, if there are just no technicians in the area, we really need to revisit that issue.

Ms. DEPARLE. It is my understanding, Senator, that we can also pay for a home health company to do it, if they are able to travel to there and a technician isn't, so perhaps we should also talk about that because many people are not aware of that availability.

Senator COLLINS. That may well be a solution.

Thank you, Mr. Chairman. Thank you, Ms. DeParle.

The CHAIRMAN. Thank you, Senator Collins.

Senator Breaux, our distinguished ranking minority member. If you want to take time for a statement as well as questions, you can do that.

[The prepared statement of Senator Breaux follows:]

United States
of America

Senator John Breaux

Democrat-Louisiana

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OPENING STATEMENT
SENATE SPECIAL COMMITTEE ON AGING
Hearing on Medicare Home Health Policy
March 31, 1998

I would first like to thank Chairman Grassley for calling this hearing to help highlight some of the problems the home health industry and the patients they serve are having as a result of the Balanced Budget Act we passed last year.

Let me emphasize that I strongly supported the budget agreement as a necessary step towards getting our fiscal house in order. I think, however, we have a responsibility to look at how the changes in home health policy are affecting agencies and beneficiaries. We cannot turn our backs on some of the unintended consequences of this legislation. Let's be up-front about the fact that the Balanced Budget Act is hundreds of pages long and there is bound to be some fine-tuning required.

Mr. Chairman, I don't think anyone would support leaving home health the way it was prior to the Balanced Budget Act. The changes Congress made to home health policy were necessary and long overdue. It is very hard to justify cost-based reimbursement for any sector in Medicare, particularly one that has increased nearly 30% a year since 1990.

Last year, the Aging Committee had a hearing to highlight some of the problems with home health. Senator Grassley, as you may recall, we got a former home health operator out of prison to talk about how she had defrauded the Medicare program and how easy it was to do so.

While that hearing underscored the fact that there were some bad actors in the program, the overwhelming majority of home health providers are honest, efficient providers who are trying to ensure high quality care for their patients. This hearing is an opportunity to hear from them.

In my state of Louisiana, the problems plaguing home health were more evident than any other state in the country. In 1996, Louisiana had the highest level of spending on home health per beneficiary and had the largest number of visits per

beneficiary. It should come as no surprise that agencies in my state would feel the effects of reductions in home health spending more acutely than most.

Since 1990, the number of agencies in Louisiana has increased from 165 to 525 so that *there are now more home health agencies than McDonald's restaurants in my state*. That is too many by anyone's count. I supported slowing the growth in home health and recognize the disproportionate effect it will have on my state but the previous spending levels were not sustainable or justifiable. What I hope this hearing will do is focus on some of the unintended consequences that these new policies have created.

We also need to monitor home health's move to prospective payment on October 1, 1999. Prospective payment will mean that every home health agency will essentially get paid the same amount for each patient they visit with some adjustments for the health status of the beneficiary. We need to make sure the playing field is level between now and then so that the good agencies are still in operation when prospective payment is implemented. My concern and the concerns I've heard expressed from many agencies is that the changes we made last year will hurt the efficient, low-cost providers while giving the inefficient, high-cost providers a competitive advantage. The practical effect of these home health changes has been to cause several low-cost agencies in Louisiana to go out of business. They simply can't compete with agencies who are getting paid thousands of dollars more and can therefore offer extra services.

As we review the changes we made to the benefit, we must listen closely to the most important parties - the Medicare beneficiaries and the home health agencies. I have heard from literally hundreds of folks on Medicare who have been affected by these changes. I have also heard from and met with dozens of agencies who supported changes to the home health benefit and recognize that there were serious problems with it but believe that the changes Congress made will hurt the wrong people. Mr. David Martin, a home health operator from Metairie, Louisiana, will give us that perspective in his testimony.

Mr. Chairman, Congress' intent in passing these home health changes last year was *not* to keep seniors in hospitals longer or force them into nursing homes sooner. The goal, rather, was to reduce spending on home health and eliminate as much of the fraud, waste and abuse in the system as we could to preserve the benefit for those who truly need it.

Again, I commend the Chairman for holding this hearing and look forward to hearing from our witnesses today about how they are being affected by the new home health policy and some of their recommendations on a better way to approach the problem.

Senator BREAUX. Thank you very much. And thank you, Ms. DeParle, for being with us. I apologize. I had another hearing at the same time and it's hard to be in two places at one time, as we all know.

Thank you for being with us. You visited Louisiana recently and had an opportunity to talk with a few home health care people while you were there.

Ms. DEPARLE. I've seen some of them this morning. I enjoyed seeing them again.

Senator BREAUX. You were able to get out of Louisiana alive? [Laughter.]

Ms. DEPARLE. Oh, yes. You have some agencies who are going to be here today, and I enjoyed talking with them down there and have enjoyed seeing them again here.

Senator BREAUX. As an overall comment, I think that the problem we have today is not like so many other problems that we deal with with Medicare, in the sense that the overall problem, at least in this Senator's opinion, is that we try and micro-manage Medicare, the Nation's largest health system, out of Washington. It is so complicated, so regulated, so restrictive, and so unrelated to normal market factors, that we get into these incredibly complicated and difficult problems about how to make sure that there's enough money to do the work that we need to do in providing health care for 38–39 million Americans.

That is the heart of the problem. We're going to continue to have problems just like this because every year Congress tries to save Medicare by what I would call the "SOS" approach, "same old/same old." Every year we try to reduce reimbursements to doctors and hospitals and medical providers, and then we say well, we've saved it again. We haven't really saved it. We've just put off the day of reckoning when we're going to have to restructure the system in order to make it more efficient, more effective, to the people it's designed to serve.

The same old/same old "SOS" is not going to work. This is the problem. Here we are talking about rates and prospective payments, interim schedules. We've got you doing interim schedules so we can get to the next schedule of prospective payments, and then who knows what else we're going to do after that. This cannot continue. I'm saying that to us, not you as Administrator. But we can't continue to try and fix it the same old way, because it's not working.

We have these hearings in the Finance Committee, debates and arguments about reimbursement rates, and I just feel we shouldn't be micromanaging it out of Washington to the extent that we do. Now, home health care was singled out as a way to reduce payments because of the enormous increase. I mean, it's been increasing at 30 percent a year.

My own State of Louisiana has over 500 home health care agencies, the largest in the Nation by far, the highest number of per patient visits, and the highest reimbursement rate per patient. There are extremely good home health care people in my State that do a very efficient and a very worthwhile job, and a very important job. But we also have some that are not efficient and that are not doing a good job.

I would really prefer that the marketplace have a great deal more to do with deciding who's good and who's bad, instead of us trying to legislate everything, to dot every "I" and cross every "T" that needs to be dotted and crossed.

So my question is with regard to where we are now. A lot of it is us. We've done this. We may be asking you questions, but Congress did the requirement for the interim payment system, to basically go to prospective payments. That's a creature of the Congress and we told you to do that. It seems to me we're telling you to do this while we're getting ready to do something else, and that the something else is better.

I mean, I would like to do prospective payment right now, and perhaps we should have done that. Perhaps we should have said all right, implement prospective payment, however long it takes you. Do that, and don't even talk about interim, because I think we made a serious mistake when we set up this interim procedure, because it's going to penalize the good operators and help the inefficient operators, exactly the opposite of what we wanted to do. I mean, we did that. The Congress passed that, thinking we were going to do something good. But what we have, in my opinion, after you look at it, is helping inefficient operators by giving them a higher reimbursement rate, and penalizing the efficient operators by giving them less than they need to continue to operate.

I think it's a mistake. We did it and we ought to try and correct it. I mean, I don't know what would happen if we just passed a law today to say stop it, but continue on with prospective payment, what would happen. That needs to be explored.

A couple of points. No. 1, on the surety bond, again the concept of the surety bond was to say, all right, we want to assure that the good operators are doing well, that there's a guarantee they will continue to do well. But I think HCFA has gone further by relating the surety bond to covering the cost of Medicare overpayments. I don't think that's right. I don't think we can do that. How do we fix that?

Ms. DEPARLE. Well, a surety bond, Senator, I believe does have that effect. It not only serves as a deterrent to folks from getting into the business, but it also is supposed to be a protection for Medicare, so that Medicare can recover if the bondholder goes out of business.

Unfortunately——

Senator BREAUX. Isn't it correct that the level we set it had an adverse effect on some of the smaller operators, who can be very efficient but not very big, and do a good job with a smaller percent of the population, but are simply not going to be able to qualify. We're going to have these surety bond people here tell us that.

Ms. DEPARLE. Yes, sir. I don't think we know that yet. I was just talking with some of your constituents from Louisiana about that, and I know some of them have had difficulties.

I have done a survey of the country to see how many agencies already have surety bonds. I think there are around 10,000 or so that are required under the law to get them, and right now, about a third of the agencies already have bonds. That is before the changes that we said we were going to make, that I talked about down in Louisiana, and that should become final——

Senator BREAUX. It's okay if you're large and big and probably don't need one anyway.

Ms. DEPARLE. Actually, I asked that same question, because I was afraid it was only going to be the large agencies who have been able to get them. But so far about 25 percent of the agencies who have already gotten bonds in hand are agencies that have reimbursements of less than $200,000 from Medicare. About 25 percent of them are between $200,000 and a million, and 50 percent are above a million.

I think what we need to do is continue to monitor this, and I will continue to give you updates on it. But——

Senator BREAUX. Is it not unusual that we would require the surety bond to cover the cost of overpayment by Medicare? I mean, isn't that an unusual request of a surety bond?

The CHAIRMAN. I think that Senator Burns was making the point that that gets closer to being a fidelity bond——

Senator BREAUX. Yes, as opposed to a surety bond. I see a lot of them are balking at that, and we'll get that testimony. But that seems to be a problem, that they're going to be responsible for overpayments by a division that they have very little control over, if at all any.

Ms. DEPARLE. Well, the problem that Medicare has—and I know you're familiar with this from your work on fraud and abuse—is that right now half the overpayments Medicare cannot collect are to home health agencies, because they avoid us. They go out of business and they don't pay back. So the surety bond would help that problem.

It does impose a higher standard, though. You're correct about that.

Senator BREAUX. Well, my time is up.

We're going to be getting a lot of information after your testimony that we're going to come back to HCFA with, to see if we can't fix this. I kind of think we ought to just do away with the interim payments and just move right to prospective pay. But again, Congress did that. That's not your idea.

You know, we do all these things and then come back and complain about what we did. We should have complained about it before we did it. I'm not blaming everybody else but me. I was there, too.

Ms. DEPARLE. It's a difficult problem.

Senator BREAUX. Thank you.

The CHAIRMAN. Would my colleagues object if I asked one more question, and then immediately go to the next panel?

Senator BREAUX. Yeah, probably. [Laughter.]

The CHAIRMAN. First of all, I understand you won't be able to stay, but I wonder if we could have somebody on your staff stay and hear the second panel? I think it's very important that they listen to the grassroots people on what the situation is.

Ms. DEPARLE. We certainly will. I have read the testimony and found it interesting, and have asked a lot of questions about it myself.

The CHAIRMAN. OK.

I would like to go back to the history of the surety bond requirement, and I would like to make reference to Congresswoman

Thurman of Florida, her involvement with this, and then getting back to what we think is the original congressional drafters' intent of the provisions. They indicated that they did not expect these bonds to be used for recoupment of overpayments.

I would like to have your reaction to the statement from Members of Congress, that they did not intend to make the surety bond a vehicle for recovery of overpayments, and is there anything we can do, short of passing another law, to influence HCFA's understanding of this congressional intent? If so, I would hope you share it.

Ms. DEPARLE. I have seen the letter that you sent, Senator, and I have also reviewed what little there was in the record about what Congress intended. I find it somewhat confusing. I certainly understand your position.

I have talked to the folks down in Florida, too, who implemented this, what they call surety bonds in Florida. They have told me that they do intend to use it to collect overpayments, but it hasn't been in place very long and I don't think they've done that yet.

I think the issue is, do you want us to be able to collect overpayments from Medicare under this. I understand that your position is that that is not what you intended. I would like to continue to work with you on that. That has been what the Inspector General recommended to us. In fact, as I noted, in their 1996 report on this, they are the ones who first recommended surety bonds to us, and they recommended to us that we get surety bonds in the amount of 100 percent of the Medicare revenues, which would have been much higher than the surety bond that we have put into place. The reason they recommended that is, I think, because of the problem we've been having with overpayments in Medicare and our inability to collect them.

The CHAIRMAN. I think it gets to a practical impact of what Congress did. If it went as far as you said, and you end up with no home health care agencies, or too few to do the work, we obviously consider home health care as such an important part of the continuum of care that we would not want that to be an end result, and I would not think it would meet the goals of HCFA, either.

Ms. DEPARLE. No, it wouldn't.

Senator BREAUX. I have just one follow up on that.

Do you know if we have other providers who are subject to surety bonds, where the surety bond is responsible for overpayments——

Ms. DEPARLE. We don't have other providers——

Senator BREAUX. Or is home health care the only one?

Ms. DEPARLE. At this point, home health is the only one. However, in the Balanced Budget Act, Congress also asked us to provide surety bonds for durable medical equipment suppliers and for some other areas of Medicare. I don't have the complete list, but I could get that for you.

Senator BREAUX. But not for nursing homes or skilled nursing facilities, or hospitals or doctors?

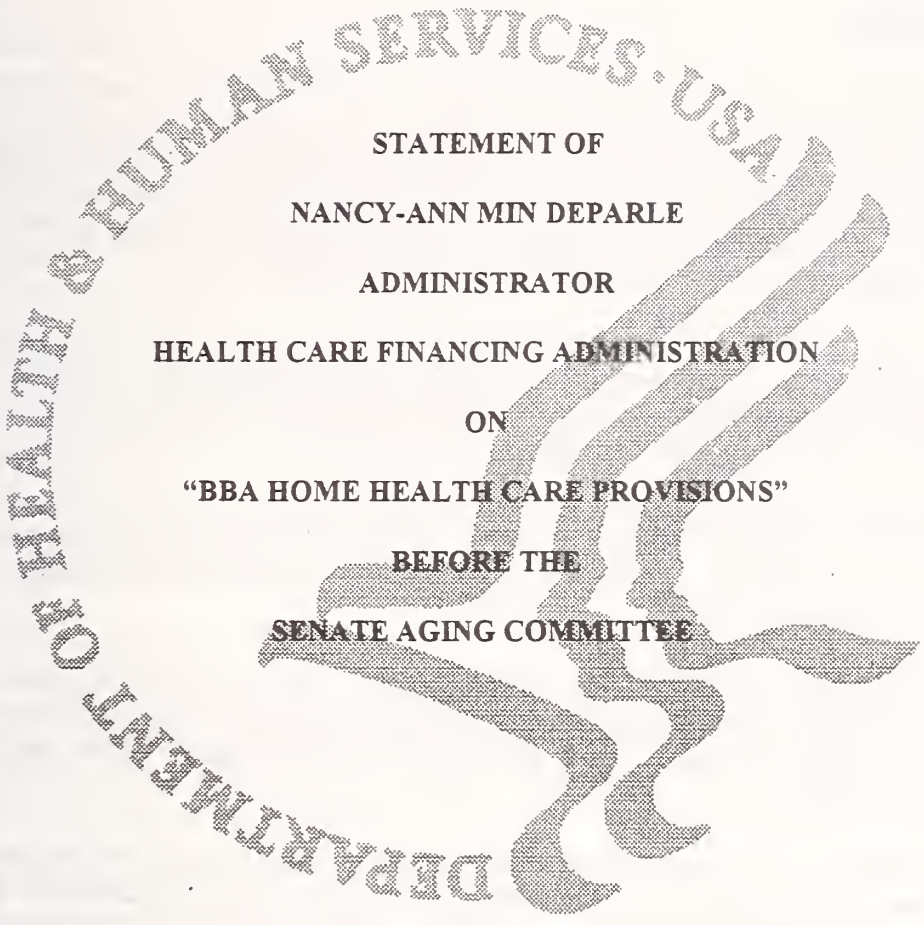
Ms. DEPARLE. I don't recall, Senator. I don't believe so. I think there were certain areas chosen.

The CHAIRMAN. OK. I thank you very much for your participation. This is a start, and this has been a part of an ongoing dialog

we've had for the last 6 weeks with you and your organization on this issue. Thank you very much for your cooperation.

Ms. DEPARLE. Thank you, Mr. Chairman.

[The prepared statement of Ms. Min DeParle follows:]



STATEMENT OF

NANCY-ANN MIN DEPARLE

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

ON

"BBA HOME HEALTH CARE PROVISIONS"

BEFORE THE

SENATE AGING COMMITTEE

MARCH 31, 1998

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

48-320 98 - 3

INTRODUCTION

Chairman Grassley and Members of the Committee, thank you for convening this hearing today to talk about a vital benefit for our Nation's seniors, Medicare home health. It is a pleasure to be here today to discuss the Health Care Financing Administration's (HCFA) implementation of the 1997 Balanced Budget Act provisions affecting home health. Together, on a bi-partisan basis, Congress and the Administration worked to produce this landmark budget agreement that strengthens and preserves the home health benefit, and Medicare overall.

Medicare's home health benefit is crucial to the 4 million beneficiaries who receive care at home. Home health beneficiaries receive services that greatly improve their quality of life. The benefit helps these patients recuperate in their own homes. Sophisticated medical treatments that were once only possible in a hospital are now available to patients at home.

Compared to the Medicare population as a whole, home health patients are more likely to be female and to live alone. These patients also tend to be poor; 43 percent have incomes below $10,000. In addition, home health users are more likely to have 2 or more activities of daily living impairments, and rate their health status as poor.

Beneficiaries are receiving home health services from the Nation's 10,500 home health agencies. The majority of these agencies are managed by and employ honest, hard-working people who provide top-quality care to our beneficiaries. Yet, sadly, home health patients are particularly at risk of victimization by bad actors.

Congress designed the home health benefit to provide care that is related to the skilled treatment of a specific illness or injury. To receive home health, a beneficiary must be under the care of a physician who has certified that medical care in the home is necessary and who has established a plan of care. Furthermore, the beneficiary must be confined to the home and must need intermittent skilled nursing care, or physical therapy, or speech language pathology services, or have a continuing need for occupational therapy. If these requirements are met, Medicare will pay for:

- skilled nursing care on a part-time or intermittent basis
- physical and occupational therapy, speech language pathology services
- medical social services
- home health aide services for personal care related to the treatment of the beneficiary's illness or injury, on a part-time or intermittent basis
- medical supplies and durable medical equipment (DME has a 20 percent beneficiary co-insurance)

Home health is an essential benefit that unfortunately has been subject to runaway growth, and waste, fraud and abuse. Congress and the Administration addressed these problems with crucial changes, including those that are the subject of this hearing -- the interim payment system,

venipuncture provision, and surety bonds. Much of the concern regarding these changes results from the challenges that often come with reform. The concern also seems to stem from misunderstandings of the changes, and the law that created and governs the benefit.

For example, the interim payment system presents challenges to home health agencies because they need to change past behavior. For the first time agencies will operate under incentives to plan and provide care efficiently. A misunderstanding of the interim payment system involves the new, aggregate per beneficiary limit contained in the system. This limit does not cap the number of visits a patient may receive, nor does it limit the amount of money that can be spent on any one patient.

Another misunderstanding of the home health benefit involves the venipuncture provision. This provision closed a loophole that let beneficiaries who only needed blood drawn, receive virtually unlimited personal care services, such as help with bathing. Critics of this provision may not understand that the Social Security Act specifically says such services can be covered only when directly related to skilled treatment of an illness or injury. The new law simply brings policy in line with the law that governs the home health benefit.

The surety bond requirement helps us to recover Medicare and Medicaid funds -- taxpayers' money -- from agencies with overpayments, civil monetary penalties or other assessments. HCFA issued a regulation implementing the bond requirement on January 5, 1998. Many agencies were able to obtain surety bonds. However, we learned that some agencies experienced difficulties, suggesting the need for technical revisions. HCFA addressed these concerns through technical revisions contained in a notice issued on March 4.

GROWTH IN HOME HEALTH

Although home care meets genuine needs in the lives of beneficiaries, many problems have been identified. Spending on home health has soared, and the benefit is susceptible to waste, fraud and abuse. There also has been sizeable growth in the number of beneficiaries receiving the services, and the benefit underwent various legislative and judicial changes. While the majority of home health agencies are legitimate providers, this provider group has also experienced changes; an alarming number of unscrupulous agencies have entered the program.

Spending has grown significantly. In 1990, Medicare program payments for home health benefits totaled $4.7 billion (in 1997 dollars) representing about 3 percent of all Medicare payments. By 1997, home health payments grew to $17.2 billion, accounting for about 9 percent of all Medicare expenditures (Attachment 1). During the same time period, the number of beneficiaries receiving home health grew from 2 million to 4 million, and average visits per beneficiary more than doubled from 36 to 80 (Attachment 2). In addition, the number of participating home health agencies grew from 5,700 in 1990 to more than 10,500 in 1997 (Attachment 3). While some of

this growth is due to changing demographics and medical advances, a significant amount cannot be explained by these factors alone.

A key turning point in the growth of the home health benefit was the Duggan v. Bowen lawsuit, settled in 1989. The outcome of the litigation, in effect, constrained HCFA's ability to deny inappropriate coverage and payments in many instances. There since has been steady growth in the number of home health visits per user and the number of users.

Growth in home health spending can also be attributed to a reduction in the number of claims HCFA is able to review for medical necessity. At a time when resources for claims review dropped, the number of claims soared. Consequently, while HCFA reviewed over 50 percent of home health claims in fiscal year 1988, by 1997, HCFA only could review about 2 percent of these claims. That is why we ask your support of the Administration's FY 1999 budget proposal to charge providers a fee to cover the costs of Medicare desk reviews, audits and cost settlement activities.

The OIG and the GAO have found high levels of inappropriate home health billings in numerous studies. In the July 1997 report, *Results of the Operation Restore Trust Audit of Medicare Home Health Services in California, Illinois, New York and Texas*, OIG evaluated a sample of 3,745 services in 250 home health claims in four states and estimated that 40 percent of the services did not meet Medicare reimbursement requirements. Similarly, GAO noted significant levels of inappropriate billings in the June 1997 report, *Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings*. A review of 80 high-dollar claims in one state revealed that 43 percent of the claims should have been partially or totally denied, and the HCFA contractor subsequently denied them.

It is important to note that the OIG has found that HCFA's fiscal intermediaries made appropriate payments based on the documentation they received from the home health agencies in the sample. However, when the OIG further examined the documentation in detail, they found that the services provided in the sample did not meet Medicare reimbursement requirements. This degree of scrutiny is simply not affordable to Medicare contractors working under tight budget constraints.

Faced with evidence of increasing waste, fraud and abuse in the home health benefit, Congress and the Administration took steps to fight the problem. The Administration's anti-fraud initiatives, including Operation Restore Trust, are providing us with the tools to crackdown on fraud. For example, 83 home health agencies in one state have been reviewed under this project since 1995. About $33 million was identified in inappropriate Medicare payments. The Health Insurance Portability and Accountability Act and the Balanced Budget Act gave us several other safeguards that already are proving successful in the fight against fraud. In addition, the anti-fraud initiatives undertaken by this Committee -- including the July 1997 hearing on "Medicare's Home Health Care Fraud and Abuse," the September home health fraud roundtable, and the

resulting draft legislation that we are working with you on, the Home Health Preservation Act -- are powerful weapons to combat waste, fraud and abuse in the benefit.

THE BALANCED BUDGET ACT OF 1997

Many of the home health provisions in the Balanced Budget Act were framed in light of the benefit's changing nature. The role of the home health benefit has broadened significantly since its inception. Congress designed the benefit to provide care that is related to the skilled treatment of a specific illness or injury. The Social Security Act contains blanket exclusions of coverage for custodial care (personal care unrelated to skilled treatment of an illness or injury) and personal comfort items. Personal care services covered under the home health benefit, such as help with bathing, are intended to augment skilled care in the overall treatment of a beneficiary who needs skilled medical care.

In addition to the need for home care among individuals who require intermittent skilled nursing, or physical, speech, or occupational therapy, there also is a demand for both custodial care and personal care services that are not covered under Medicare. We believe that a good share of the increase in utilization reflects an attempt to meet these needs. Evidence shows that the increase in utilization is largely due to the rising number of home health aide visits for personal care in recent years.

With the support of many Members of this Committee, the Balanced Budget Act made the most significant changes in Medicare and Medicaid since they were enacted more than 30 years ago. This budget agreement is a major step forward by Congress and the Administration in the effort to preserve the home health benefit and strengthen Medicare overall. We are pleased to have the new authorities contained in the law, and are already putting in place significant new tools to control the runaway growth in home health spending, and waste, fraud and abuse. Among these authorities are the home health prospective payment system and the three provisions that are the focus of this hearing: the interim payment system, venipuncture, and surety bonds.

As HCFA implements the Balanced Budget Act, we are monitoring its impact closely. We continually meet with home health industry representatives to hear about the challenges they face in adjusting to the legislative changes. HCFA also has sent letters to each home health agency about the Balanced Budget Act. For example, in one letter we reminded agencies about their responsibility to advise patients accurately of their coverage under the home health benefit (Attachment 4). HCFA had grown concerned about reports that information on the legislative changes were misinterpreted by home health agencies.

INTERIM PAYMENT SYSTEM

The Balanced Budget Act includes major reforms in home health payment. Historically, home health agencies have been paid on the basis of their reasonable costs. Within the home health cost

limits, HCFA was required to pay the agency the allowable cost it incurred in providing care. This type of payment, known as cost-based reimbursement, has been widely criticized. There is no incentive for operating efficiently, minimizing costs, or controlling the number of visits supplied. In fact, prior to the Balanced Budget Act, agencies had the incentive to maximize the number of visits to each beneficiary. More visits meant more payments to the agency.

The Congress, the Administration, and the home health industry all agree that Medicare home health should move to a prospective payment system to control costs and ensure quality and access to care. The Balanced Budget Act establishes such a system, to be implemented by October 1, 1999, a target HCFA is working hard to meet. Until then, Congress prescribed an interim payment system that took effect October 1, 1997.

Under a prospective payment system, efficient providers are rewarded while inefficient providers are penalized. In order for this payment system to work, differences in the severity of patients' conditions must be described. These differences must be explained by a "case-mix adjuster." Currently, a reliable case-mix adjuster does not exist for home health. The interim payment system was established to control the runaway growth in home health while HCFA works to develop an accurate case-mix adjuster.

The interim payment system will pay agencies the lower of their actual costs, or one of two cost limits. Home health agencies will continue to be paid on a cost basis, but the total payment to an agency is controlled by two limits. The first is the aggregate limit based on per visit costs. The second is a new aggregate per beneficiary limit. Together, the two limits are designed to tackle different problems with overuse, or waste of services, stemming from cost-based reimbursement. The aggregate limit based on per visit costs encourages agencies to provide services more efficiently during each visit than they did in the past. The aggregate per beneficiary limit promotes efficiency in planning and delivering total services to the patient through the entire home health stay. This limit also takes away the incentive to supply medically unnecessary visits to maximize Medicare payment, but it does not limit the actual number of visits to any one patient.

Prior to the Balanced Budget Act, only the aggregate limit based on per visit costs applied to home health agencies. The law reduces this limit from 112 percent of the mean per visit cost of care to 105 percent of the median per visit cost of care. The aggregate limit based on per visit costs encourages agencies to provide care efficiently in order to keep their costs within the limit. As required by the Balanced Budget Act, the regulation implementing the aggregate limit based on per visit costs was published in the *Federal Register* on January 2, 1998.

The new aggregate per beneficiary limit encourages agencies to plan and deliver care more efficiently by consolidating visits and eliminating unnecessary ones. This limit primarily is based upon the agency's own costs and patient mix -- its costs and patient mix in fiscal year 1994. The aggregate per beneficiary cap is adjusted further to blend the agency's own costs with costs from the census region, to compress the range of extreme values that might otherwise result.

New home health agencies will have an aggregate per beneficiary limit that is the national median of the limits for existing agencies. This national median discourages further development of agencies in areas where utilization and costs are already high.

The interim payment system, like any payment reforms Congress has prescribed in the past, present challenges for providers. The home health reforms are designed to change agencies' past behavior. The incentive to supply virtually unlimited visits to patients regardless of medical outcome is gone. Instead, home health agencies now must make decisions based on the patient's medical outcome and on efficiency in planning and delivering care. The law creates incentives to scale back utilization to fiscal year 1994 levels. On average, this would be a reduction of about 12 visits per year, or 1 visit per patient each month. Of course, for any one agency, the actual experience could vary. Under the interim payment system, home health agencies now have an incentive to combine visits, eliminate unnecessary ones, or reduce overhead expenses.

The limit under the interim payment system that appears to be causing the most concern is the aggregate per beneficiary limit. This limit essentially charges agencies with the responsibility of operating within a global budget to provide Medicare covered services. The aggregate per beneficiary limit does not restrict the number of visits to individual patients, nor does it limit the amount of money a home health agency can spend in caring for any one patient.

Under the aggregate per beneficiary limit, agencies are still able to meet the varying health needs of their patient population. The limit simply captures, as an average, the full range of patients served in FY 1994. This includes high cost or sicker patients, and low cost patients. Although some claim that home health patients are being discharged from hospitals sooner than before, this argument does not apply to most beneficiaries receiving home health. A study published in *The New England Journal of Medicine* in August 1996 found, "less than a quarter of home health visits (22 percent) were preceded by a hospital stay within 30 days. Nearly half the visits (43 percent) were unassociated with an inpatient stay in the previous six months."

We believe home health agencies have the flexibility to provide the appropriate amount of care (duration of visits, number of visits, and skill level of caregiver) within the aggregate per beneficiary limit. Applying the limit to the agency overall, not just to one patient, allows the agencies to balance the cost of caring for one patient against the cost of caring for others. Mandating that home health agencies operate within a global budget should not mean that care is compromised to any patient. Agencies are bound by their participation agreement with Medicare to provide the appropriate levels of care that the physician prescribes.

It is important to note that Medicare's home health benefit has always emphasized providing covered services in the fewest number of visits needed to achieve the goals of the patient's plan of care. Medicare also has always covered the teaching and training of the patient and his or her family to carry out services themselves. During the past several years, these principles seem to have been eroded by the perverse incentives inherent in cost-based reimbursement. We believe

that returning to the principles of delivering covered care in the fewest number of visits to achieve the plan of care; teaching and training the patient and the family; planning and furnishing care efficiently; and enrolling truly eligible beneficiaries in home health, will enable home health agencies to operate within the new interim payment system.

VENIPUNCTURE

The venipuncture provision in the Balanced Budget Act closed a loophole in the home health benefit. Prior to the budget agreement, venipuncture for a blood draw triggered the potential for virtually unlimited home health visits even when the beneficiary did not require skilled medical care. However, under the Balanced Budget Act, only individuals needing other skilled therapy or nursing services in addition to venipuncture can continue to receive blood draws through the home health benefit.

Medicare still pays for blood draws that are not associated with home health services. This service is paid under the Part B laboratory benefit. If a beneficiary is unable to travel to a laboratory or a physician's office for the blood draw, Medicare Part B will pay for a technician to travel to the beneficiary's residence to draw blood. HCFA has heard concerns that in some parts of the country, the payment for technician travel may be inadequate. We are reviewing the payment policy to ensure that beneficiaries receive needed blood testing. As an alternative to technicians traveling to a beneficiary's residence, a physician, nurse practitioner, clinical nurse specialist or a physician assistant can conduct a home visit and draw blood when they examine the beneficiary.

Medical review staff at HCFA's contractors found numerous examples of abuse associated with venipuncture. For example, the contractors discovered cases where beneficiaries were taking a blood thinning drug, but needed no other skilled treatment. Physicians ordered skilled nursing visits to draw blood for laboratory testing (for adjustment of drug dose), and home health aide services for these individuals. In one case, there was no evidence that the patient needed skilled treatment but skilled nursing visits were prescribed 1-2 times per week, and a home health aide was ordered for 12 hours a day, 7 days a week to assist in showering, meal preparation, shopping, laundry, housekeeping, safety supervision, and escorting.

The venipuncture provision targets this inappropriate use of home health services. It also ensures that beneficiaries receive care that is covered under law by focusing limited Medicare resources on the mandate to serve persons with medical and remedial care needs, rather than those requiring only custodial care. The venipuncture provision went into effect February 5, 1998.

SURETY BONDS

The Medicare home health benefit is crucial for many beneficiaries but unfortunately, it has been abused by some unscrupulous providers. As a way of using market forces to protect beneficiaries

and the Medicare and Medicaid programs, Congress enacted a provision in the Balanced Budget Act requiring home health agencies to obtain surety bonds. Many industries use surety bonds to protect consumers. For example, a "bonded" carpenter is hired to build bookshelves in a house. In the course of performing the work, the carpenter accidentally breaks a window. Should the carpenter refuse (or be unable) to pay, the homeowner can collect for the replacement of the window from the surety company. Medicare finds itself in a similar situation.

Because of the success of a surety bond requirement imposed by the Florida Medicaid program, we know that this approach works. This State bond requirement, combined with additional anti-fraud measures, resulted in savings of $200 million over a two-year period for Florida. Although there has been a decline in the number of Medicaid home health agencies, the State of Florida has received no complaints from physicians or patients regarding access to care problems. The Federal surety bond requirement will help Medicare and Medicaid to recover funds from agencies who have incurred overpayments, or who have had civil monetary penalties or assessments imposed against them.

HCFA published a regulation to implement the surety bond requirement in the *Federal Register* on January 5, 1998. Our goal is to implement the most effective regulation possible to protect Medicare, Medicaid, and our beneficiaries. While many agencies already have obtained surety bonds, we learned that some agencies experienced difficulties. HCFA addressed these concerns through technical revisions.

These technical issues are detailed in a notice published in the *Federal Register* on March 4, 1998. They are in keeping with standard industry practice, and would help surety companies offer bonds at more affordable prices to agencies. The technical revisions will:

- **Limit liability to the bond in effect when it is determined that funds are owed to Medicare, regardless of when the overpayment or misdeed took place.**
  Bond companies will be liable only for determinations made during the year for which the bond is written, or the "period of discovery." This ensures that bond companies are not responsible for money owed to Medicare for several years after a bond expires. Bond companies' actual risk will be easier to determine, making bonds more affordable.

- **Establish that bond companies have liability for an additional two years when a home health agency leaves Medicare and Medicaid.**
  The term of the bond will automatically extend two years after the date an agency is terminated, voluntarily or not. This provides additional protection for Medicare and Medicaid, and sets a clear limit on bond companies' liability when an agency is terminated.

- **Give bond companies the right to appeal overpayment assessments if an agency fails to assign its right of appeal to the company.**

This technical revision recognizes that bond companies should have appeal rights. However companies would not be able to appeal if an agency has appealed and lost.

The technical revisions in this *Federal Register* notice, and the comments on the original regulation published on January 5, will form the basis for a final rule. Our goal in the final rule is to protect Medicare and Medicaid without unduly burdening reputable providers.

The original regulation published on January 5, requires agencies to submit bonds to the Medicare fiscal intermediary that processes their claims by February 27. As noted, many agencies have already obtained surety bonds. For these agencies, the bond should be submitted to the fiscal intermediary. However, other home health agencies have been unable to obtain bonds. In the technical notice, agencies were asked to notify their fiscal intermediary or State Medicaid agency of this fact in writing by March 31. This allows us to make an accurate assessment of the number of home health agencies without bonds.

The original February 27 effective date has been extended in a rule, accompanying the technical notice, that also was published in the *Federal Register* on March 4. The new compliance deadline will be 60 days after the publication date of a final surety bond rule that incorporates comments on the January 5 regulation and the subsequent technical revisions. For home health agencies that have not furnished surety bonds, HCFA will not take action to terminate or withhold payment until the new compliance date.

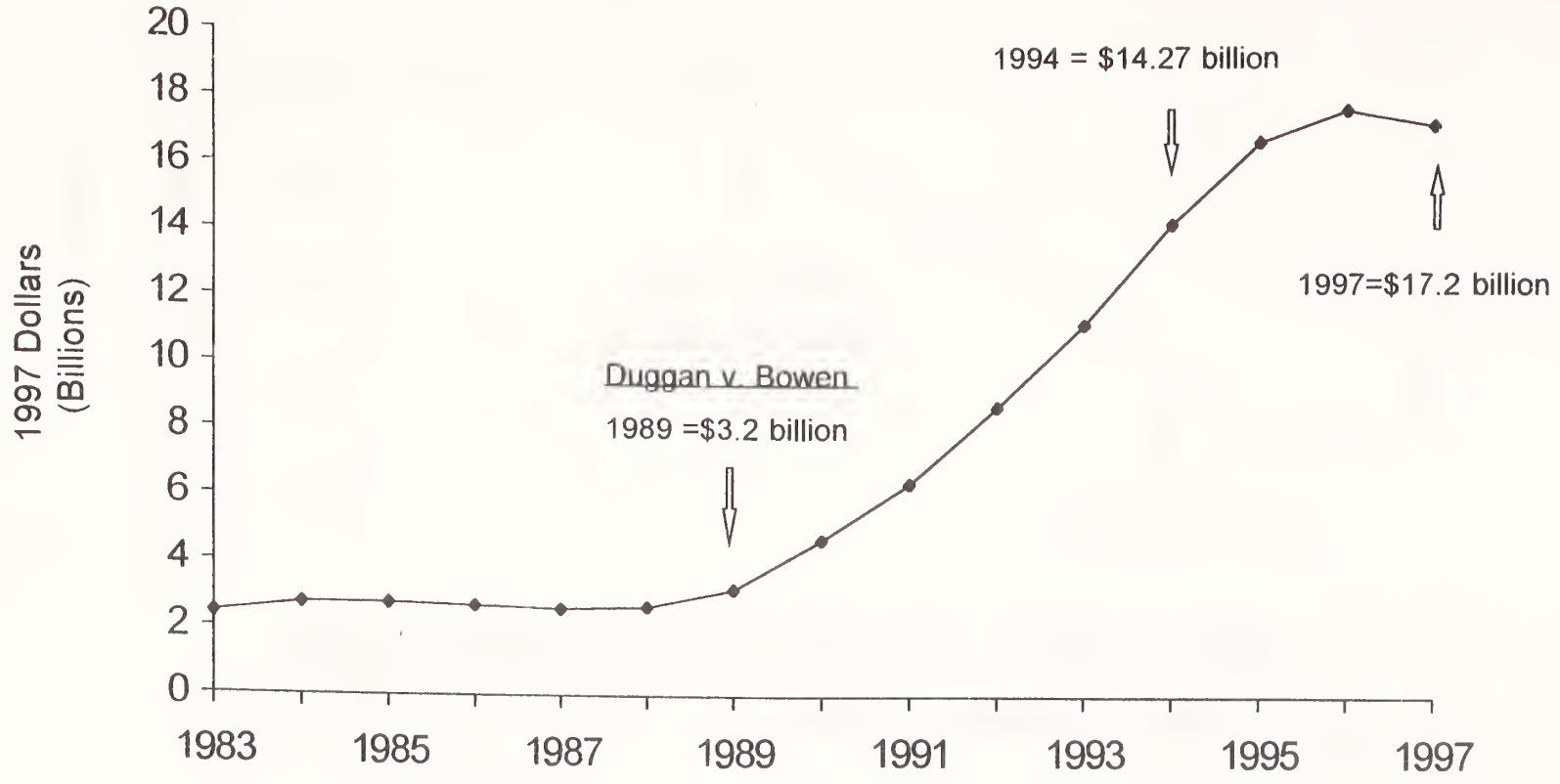
CONCLUSION

The Balanced Budget Act of 1997 dramatically reforms the Medicare home health benefit. The budget agreement includes measures that achieve savings of $17 billion in five years. The Balanced Budget Act also includes other provisions that go a long way to strengthen and preserve the benefit, including the surety bond requirement and the venipuncture provision.

Given the rapid growth, and the waste, fraud and abuse in the benefit, these major changes are needed. We know that often with change comes challenges. The Balanced Budget Act is no exception. Home health agencies are being asked to change past behavior by planning and delivering care more efficiently, and by providing only the services that are covered under law. Congress and the Administration also are asking agencies to be better managers of the taxpayers' money. We believe that the majority of our home health agencies can succeed in facing the challenges, and carry out the changes that will help safeguard the benefit.

ATTACHMENT 1

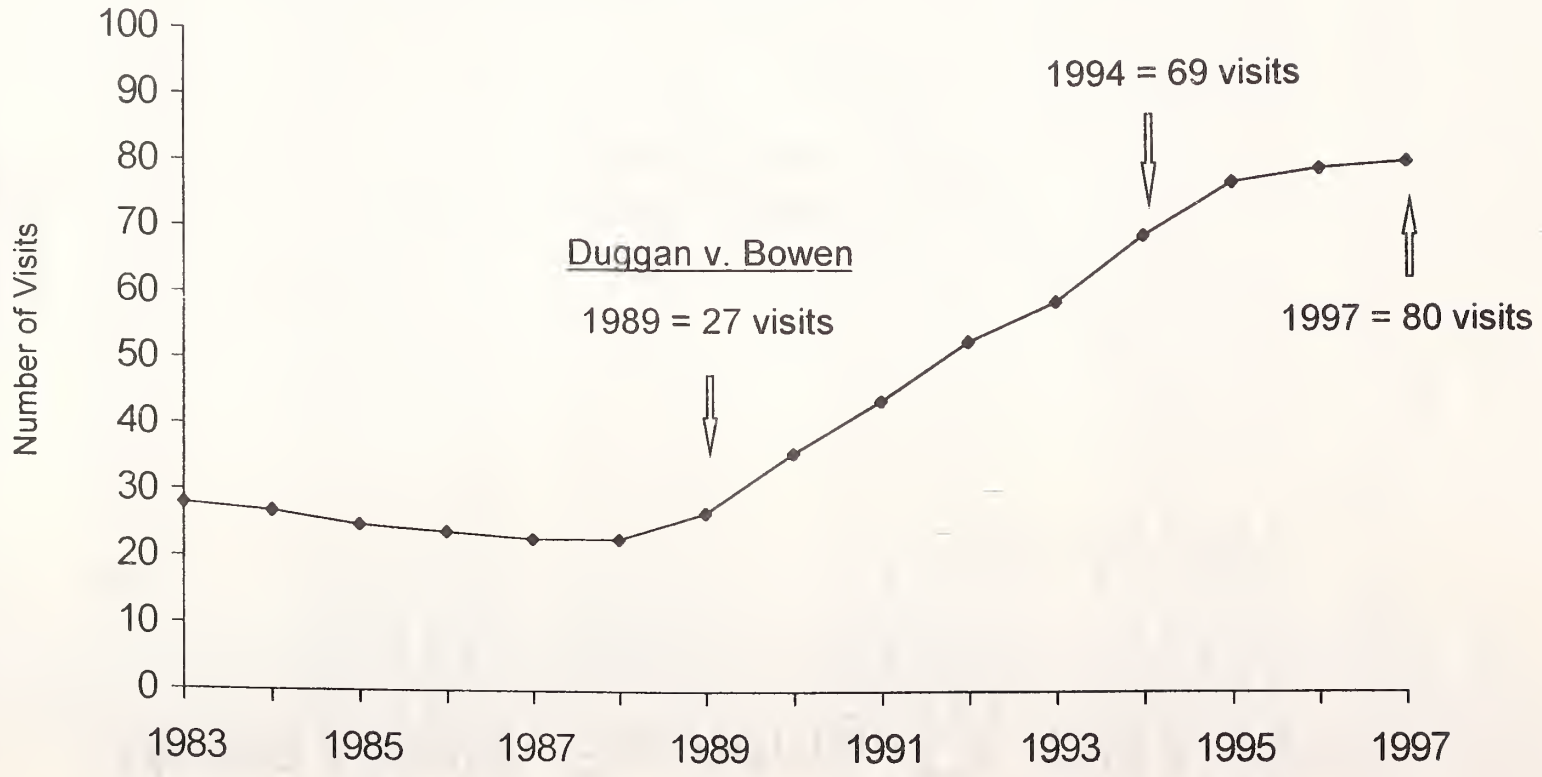
Home Health Spending, CY 1983-1997



Source: HCFA, Office of the Actuary.

ATTACHMENT 2

Average Number of Home Health Visits per Medicare Beneficiary, CY 1983-1997



Source: HCFA, Office of the Actuary.

ATTACHMENT 3

Number of Home Health Agencies Particpating in Medicare, CY 1988-1997

Source: HCFA.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

The Administrator
Washington, D C 20201

Attachment 4

DATE: February 3, 1998

TO: All Home Health Agencies Serving Medicare

The Balanced Budget Act of 1997 enacted several Medicare payment reforms intended to ensure that enrollees get the care they need and that Medicare is billed correctly. I am alarmed by reports that some homebound Medicare enrollees are being frightened by inaccurate information about changes in coverage, and that some HHAs may be terminating care for Medicare enrollees and blaming the payment reforms. This letter provides clarification of reforms in home health payment to help you inform and care for Medicare enrollees appropriately.

The Secretary of Health and Human Services is required to establish an interim payment system while a prospective payment system is developed. This interim system establishes two types of payment caps: one is a revised routine cost cap per visit, and one is an aggregate cap based on either the average cost per beneficiary at each home health agency (HHA) and the region in which it is located, or the median of aggregate limits applied to other HHAs. HHAs will be paid the lesser of 1) their actual costs, as before; 2) the per visit cap; or 3) the aggregate cap.

The new aggregate cap reflects the typical utilization of home health services for each HHA during the FY 1994 base period established by Congress. It allows HHAs to balance the cost of caring for any one patient against the cost of caring for all patients. We believe all Medicare enrollees can be safely and effectively cared for under this payment system by HHAs that deliver quality care efficiently.

The Balanced Budget Act also makes clear that the need for venipuncture alone does not qualify a homebound Medicare enrollee for other home health services. Beginning February 5, 1998, homebound patients who need blood drawn but who do not qualify for home health services will be entitled to venipuncture services provided by laboratory technicians under Medicare's laboratory benefit. Homebound Medicare enrollees who need blood drawn and who also qualify for other home health services can continue to have venipuncture services provided by home health agency staff under Medicare's home health benefit.

--MORE--

The Medicare Conditions of Participation require HHAs to provide accurate information to their patients about Medicare coverage and payment. Medicare enrollees must be informed about what services are and are not covered, and they have a right to participate in care planning. HHAs are not free to reduce the amount of care ordered for patients by physicians.

HHAs in Medicare are not allowed to discriminate against Medicare enrollees. If an HHA accepts non-Medicare enrollees at a given level of severity, it must also accept Medicare enrollees at similar levels of severity. HHAs that provide services to non-Medicare patients while refusing services to similarly situated Medicare patients risk having their provider agreements terminated and being barred from billing Medicare.

Any reports of HHAs misinforming beneficiaries or inappropriately terminating care for Medicare enrollees will be considered the basis for a complaint survey that could lead to termination of the HHA from Medicare.

I know you share our concerns on this issue, and I want to thank you for your continued efforts in trying to provide Medicare enrollees with the best care possible in the most efficient manner possible. I look forward to working with you on this and other important home health issues.

Sincerely,

Nancy-Ann Min DeParle
Administrator

The CHAIRMAN. I would ask everybody who is on the second panel just to come to the table. I'm not going to take the 5 minutes it will take to introduce each of you. I would ask that you tell us who you are at the start of your testimony.

Would everybody on the second panel please come to the table right now. I am going to go from my left to my right, so that means Ms. Barbara Smith would lead off. I would emphasize the 5-minute limitation because of the fact that we're running a little bit late. That's not your fault. That's the vote's fault. But we're still running late.

So would you each just give maybe about a 15 second or so background about who you are, where you come from, and your interest, so I don't have to take the time to do that.

STATEMENT OF BARBARA MARKHAM SMITH, SENIOR RESEARCH STAFF, CENTER FOR HEALTH POLICY RESEARCH, GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER

Ms. SMITH. Thank you, Senator. I am Barbara Smith. I'm with the Center for Health Policy Research at George Washington University Medical Center.

We released a report yesterday analyzing the impact of the Medicare home care provisions on access and quality of care for home care beneficiaries, which is why I'm here today. Because I have submitted in my written testimony, I'm just going to summarize some of the key points of the report.

The CHAIRMAN. Let me make that point, too, for all of you. Your entire written testimony will be put in the record and printed as part of our hearing.

Ms. SMITH. Mr. Chairman, if I could also ask that the report itself be made a part of the record.

The CHAIRMAN. Yes.

Ms. SMITH. The main findings of the study can be summarized as follows:

The home care population represents an increasingly sicker population, requiring more acute management of chronic illness and higher intensity acute care;

The Balanced Budget Act's reductions in Medicare home health coverage and financing can be expected to affect the sickest, frailest and highest cost beneficiaries and punish the very agencies that specialize in the care of those sickest patients.

The most severe effects of the interim payment system will fall on the sickest patients living in those States which historically have had the lowest utilization.

The interim payment system we believe will also shift costs to other payers—notably Medicaid—while rewarding inefficient agencies who care for relatively healthier patients.

If I could just elaborate a bit on the effect on Medicaid, because we know there is a fairly strong substitution effect between Medicare and Medicaid on home care services; that is, where there is high Medicare utilization of home care services, there tends to be very low Medicaid utilization, and vice versa.

Our concern, among other things, is that as States begin to fear they will have to pick up a larger share of the home health bill in their Medicaid program, they will tend to conserve State resources

in anticipation of that expenditure which in turn, may affect the implementation of the child health insurance program. Our concern is that States will pull back on some of their expansions in child health coverage in order to accommodate the greater demand for Medicaid home health care.

Finally, we believe that this interim payment system, as devised, will make it more difficult to ultimately implement and design the permanent prospective payment system because it will result in a skewing of the data collected over the interim period.

We make a series of recommendations for changes that I would be happy to share with you.

First of all, just by way of background, let me say that Medicare home care beneficiaries fall into fairly defined categories of utilization that should actually make the system fairly easy to amend. They fall into roughly three equal categories by numbers, but by utilization they separate out quite differently.

The least cost patients are those that use it for short-term, post-hospital recovery—the hip fracture patient who needs some physical therapy at home, for example. Those tend to be fairly low cost patients, who have a very defined number of visits.

The second category of patients, which is also roughly a third of that population, are what we would call medically complex and unstable. That is, they have complex physical and medical problems, combined with limitations on their daily functions. You might think of this patient as being a stroke victim and who maybe is unable to perform two activities of daily living, and also has severe and unstable diabetes. These medically complex and disabled patients consume about 43 percent of home care costs.

The third category of patients are those who have high levels of functional impairments and also chronic diseases, but they are relatively medically stable. They need ongoing acute management of their chronic diseases, but they are not relying on home care primarily for personal care. It is for acute management of stable chronic diseases.

From these groups there is a subset of extremely high users. These are people who use the Medicare home care benefit for more than 200 visits a year. They account for 43 percent of the cost. They are very medically unstable. They have multiple hospitalizations in a year. They tend to go back and forth between the hospital, home care, and skilled nursing facilities. Again, they are usually relying on home care for acute management of chronic, serious, ongoing conditions.

What we recommend, then, based on the way the patients break out, is a number of options. I see my time is up. Would you like me to do that quickly?

The CHAIRMAN. Yes, please.

Ms. SMITH. The first option is, just as Senator Breaux suggested, having a moratorium on the interim payment system, leaving in place the per-visit limits, but taking out the per-beneficiary cap. This would, of course, limit the savings under the program.

The second alternative would be to set up a system which is more risk adjusted and, therefore, discriminates less against sick beneficiaries, by dividing payments into four different levels, based on the four categories of utilization I have just described. That

would tend to create a more normative standard and it would also have inherent in it a risk selection system that creates fewer disincentives for caring for very sick people.

The third possibility would be to do a two-step system; in other words, to have a short stay/long stay bifurcation. I don't think that's quite as sensitive a mechanism as doing a four-category mechanism, but it still enables sicker patients to be cared for.

Alternatively, HCFA has a demonstration program in place that is similar to the hospital-based DRG system. It's an episode-based system. They have 18 different episodes and payment would be based on those separate episodes. That demonstration program is in place and has been moderately successful.

We also make recommendations regarding venipuncture and the definitions of intermittent and skilled nursing care, but I will leave that for the record.

The CHAIRMAN. OK.

[The prepared statement of Ms. Smith follows:]

Testimony of Barbara Markham Smith, J.D.
Center for Health Policy Research
George Washington University Medical Center
before the United States Senate Special Committee on Aging
March 31, 1998

Good morning, Mr. Chairman. I appreciate being able to be here today to discuss the findings of a report just released by the Center for Health Policy Research, Medicare Home Health Services: An Analysis of the Implications of the Balanced Budget Act of 1997 for Access and Quality. I will briefly summarize the findings and recommendations of that analysis.

Background and Overview

Home health care is an essential service for millions of acutely and chronically ill people, including the nearly 3.3 million elderly and disabled Medicare beneficiaries who used the Medicare home health benefit in 1994. Between 1987 and 1996, expenditures for Medicare home health services experienced unprecedented growth. This growth in spending is attributed primarily to growth in the number of beneficiaries served and in the increase in intensity of care rather than price.

Many factors contributed to this large growth in the number of beneficiaries and services: expanded coverage (accomplished both through legislation and judicial decisions) lifting limits on the number of services beneficiaries could receive and enabling more beneficiaries who need acute care services in the management of chronic illness to qualify for the benefit, an increasingly ill acute care population, and demographic and technological changes making it possible to deliver more sophisticated care at home to an older population.

While less than 10% of the Medicare population uses home health services, the beneficiaries are generally poorer, sicker, predominantly female, more likely to live alone, and have more functional impairments than the Medicare population generally. They can be divided into roughly three equal groups. The first group represents the traditional post-hospitalization acute care need and generates approximately 22% of Medicare's home care costs. The second group can be characterized as "medically complex," seriously ill people with unstable medical conditions combined with functional impairments and requiring multiple institutional admissions. This group generates approximately 42.5% of Medicare home health costs. The third group represents beneficiaries who use the home health benefit for acute care services that meet the medical management needs generated by chronic illnesses. They account for 35% of home health expenditures. Taken from these groups is a subset of home health care users who represent extremely high utilization.

requiring more than 200 visits per year and accounting for 43% of Medicare's home health costs while comprising 10% of the home care population. These people tend to have extremely complex medical needs combined with serious multiple impairments and multiple episodes of acute hospitalizations.

These statistics demonstrate that the Medicare home health benefit has become a significant safety net for elderly and disabled Americans. The challenge for changes in reimbursement is to reduce unnecessary utilization without adversely affecting the health status of very vulnerable beneficiaries or increasing costs in other health sectors.

Changes in Home Health Payment Under the Balanced Budget Act

In order to slow the expenditure growth in Medicare's home health benefit, the Balanced Budget Act (BBA) implemented changes in reimbursement designed to yield more than $16 billion in savings over a five-year period. In order to achieve these savings, the BBA mandates two payment systems -- an interim payment system that operates from FY 1998-1999, and a new prospective payment system (PPS) to be developed by the Secretary of Health and Human Services according to certain policy objectives and to begin in FY 2000.

The interim payment system potentially creates the most adverse consequences in the BBA; moreover, its interaction with other home health care-related provisions may intensify these effects. Under the interim system, the BBA extends the two year freeze on per visit cost limits imposed in 1994 by assuming that inflation for those two years was zero. Market basket updates resume in 1996. The BBA also reduces the per visit reimbursement formula by reducing the rate to 105% of the national median, from 112% of the national mean. These changes are consistent with traditional Medicare policies to reduce payment on a per visit basis.

In addition to these changes, the interim payment system imposes total payment limits based on an agency's average cost per beneficiary in FY 1994, minus 2%, and adjusted for an agency-specific/ regional blend. In other words, to encourage more efficient utilization, the BBA limits payments for each agency to the per visit limits multiplied by the average number of visits per beneficiary delivered by that agency in FY 1994 .

Apart from changes in the payment system, the BBA implemented other permanent changes regarding the structure of and eligibility for the home health benefit that may affect access to services. These include transferring home health payments not associated with a three-day hospitalization to Medicare Part B, basing payment on the costs of the location where services are delivered rather than the costs of the location of the business offices of home health agencies, clarifying the definition of part-time and intermittent care,

eliminating venipuncture as a service that may qualify beneficiaries for other home care services, and establishing normative standards for service denials.

Impact of the Balanced Budget Act on Home Health Services

Among the many changes in Medicare home health care under the BBA, the interim payment system is likely to have the greatest unintended adverse consequences. The probable results of the interim payment methodology are to create strong incentives to limit or deny care to the sickest beneficiaries, to reward historically inefficient providers, and to make the ultimate PPS system scheduled to take effect in FY 2000 much more difficult to design and implement.

First, because under the BBA, home health agencies can only be reimbursed for the average number of visits per beneficiary in FY 1994, they have strong incentives to limit care to those patients who require no more than the average number of such visits. An agency effectively loses money if its case mix of patients require more visits than the average beneficiary did in FY 1994. Alternatively, agencies can accept such patients but attempt to reduce care to a level as close to the average as possible, regardless of the condition of the patient. This occurs because the interim payment system contains no case-mix adjuster or other adjustment tool to compensate agencies who care for sicker patients.

Under the interim system, the sickest patients will experience the most problems. This is because this payment methodology creates perverse incentives in the way it attempts to control utilization. While efficient agencies who care for very sick patients will have higher averages than efficient agencies who care for less sick patients, they may have lower averages than inefficient agencies who care for less sick patients. Efficient providers of care for very ill patients may have to reduce necessary services, serve a healthier clientele, or leave the market. The inefficient agency, on the other hand, can reduce services more easily and still have the financial advantage of an historically higher average. As a result, providers that care for the sickest patients will become less available and those patients may have substantial difficulty being accepted by other agencies.

In addition to creating substantial disincentives to care for sicker and more disabled patients, the interim payment system substitutes an agency-specific total payment methodology for a national payment methodology while locking in historic differences in practice patterns, both regionally and by agency. This will make it more difficult to move to a final PPS methodology because it will be more difficult to establish normative patterns of service delivery and obtain the data necessary to implement PPS.

The access and quality problems posed for very fragile beneficiaries are compounded by changes in rules governing eligibility for home care services. Specifically, eliminating venipuncture as the threshold by which beneficiaries may qualify for home care services will unquestionably reduce the number of Medicare beneficiaries

receiving the benefit. However, it is not clear whether those other services will be available in any other sector for these beneficiaries. For example, it is unclear that state Medicaid programs can accommodate these needs or that other state home care services will be available. The lack of alternative financing and delivery infrastructure suggests that many Medicare beneficiaries will be left without services on which they have depended for the management of chronic illnesses and disabilities.

Restrictions on part-time and intermittent care which are designed to limit the provision of long-term daily care will have similar effects. To the extent that limitations on the duration of care result in more denials of care, sicker beneficiaries may be effectively without coverage for long-term acute care management unless state Medicaid agencies elect to fill the void. Given these agencies' own efforts to contain costs, such an expansion may be unlikely.

The main findings of this study can be summarized as follows:

- the home care population represents an increasingly sicker population requiring more acute management of chronic illness and higher intensity acute care;
- the BBA's reductions in Medicare home health coverage and financing can be expected to affect the sickest and highest cost patients and punish the very agencies that specialize in the provision of care to this population;
- the most severe effects of the interim payment system will fall on the sickest patients living in states with the lowest historical utilization patterns;
- the BBA's interim payment system will shift costs to other payers (notably Medicaid) while rewarding inefficient agencies who care for relatively healthier patients; and
- the interim payment system will make it more difficult to design and implement the permanent prospective payment system scheduled to become effective in FY 2000.

Conclusion and Recommendations

Because of the adverse consequences associated with the BBA revisions to the Medicare home care benefit and its payment, this report proposes five options to maintain access to necessary care, reduce excess utilization, and facilitate transition to a final PPS methodology. These options include: (1) a moratorium on the interim payment system coupled with acceleration of the implementation of a case-mix adjusted PPS system; (2) implementation of an interim episode-based PPS system, analogous to the hospital

diagnosis-related group (DRG) system, based on current demonstration projects administered by the Health Care Financing Administration (HCFA); (3) implementation of an interim simplified risk-adjusted payment system based on the four categories of spending and use patterns among Medicare beneficiaries described above, notably post-acute, unstable medically complex, stable acute management of chronic illness, and high intensity long term medically complex; (4) implementation of a two-level per beneficiary cost-limit based on short stay or long-stay designations; and (5) reexamination of eligibility and coverage changes included in the BBA.

All of these options substantially reduce the disincentives to deny care to very sick beneficiaries by providing for additional payments for those beneficiaries while providing incentives for less efficient agencies to change practice patterns. Under these approaches, the reimbursement rests on standard payments modified to reflect the illness severity of the patient. In addition, the report recommends phasing in changes in service eligibility or duration to assure that seriously ill patients are not left without sources of care. The goal here is to allow time for alternative infrastructure to develop to care for patients whose care is pushed out of the Medicare system.

The eligibility and payment systems under the BBA fail both the tests of rewarding efficiency and assuring appropriate access to care. The costs of such failure both in social and financial terms are potentially significant, necessitating early revision of the interim payment methodology and a reexamination of coverage requirements.

The CHAIRMAN. Ms. Slack.

STATEMENT OF CINDI SLACK, EXECUTIVE DIRECTOR, SIOUX VALLEY HOSPITAL VISITING NURSES ASSOCIATION, SIOUX FALLS, SD

Ms. SLACK. Thank you, Mr. Chairman, for inviting me here today.

I am Cindi Slack, and I'm the Executive Director of the Sioux Valley Hospital Visiting Nurses Association, located in Sioux Falls, SD.

The VNA is and has been one of South Dakota's lowest cost providers since 1966. Under the interim payment system, the VNA's per-beneficiary aggregate limit will be, as we have calculated, $1,585, which is significantly lower than our costs, which are already extraordinarily low in the aggregate. Sources at the National Association of Home Care and the Visiting Nurses Association of America have indicated to me that this limit may well be one of the lowest limits in the country. It is well below any region census division reimbursement per person, as noted on the chart that I enclosed in your packet.

The effect of IPS essentially punishes those agencies that have historically been low-cost providers, and rewards those agencies with high costs, as we have already heard this morning.

Some specific examples include our agency, which provides only 34 visits per patient currently, and the national average from 1995 data is 75 visits per patient. Our current cost is $77 per nursing visit, while the national average cost per nursing visit in 1997 was $98. In 1993, our cost was $74.76 per nursing visit. The significance of that change is that our cost per visit increased less than one-half of one percent annually from 1993 to 1997.

We have estimated that in order to break even with IPS, we would need to decrease our visits per patient, again in the aggregate, from an average of 34 to an average of 19 visits, at the same time that we are seeing patients with intensified medical and nursing needs, and the IPS does not provide for this variance.

Additionally, much has changed in the State of South Dakota since 1993. Not only have home health agencies been affected by the decreased length of stay of patients within hospitals, but home care was also affected by a policy decision of our Governor which privatized services. As a result of the privatization of home health, our State ceased to employ nurses to provide skilled nursing services and terminated the statewide coverage of its home health agency. As a result, the counties of Brule and Lyman, noted on the map I enclosed, had no home care providers. The VNA sought to meet the needs of this rural area and expanded its services through a branch office located in Chamberlain, SD.

The IPS is of major concern to the home health agencies located in South Dakota's most rural areas. A colleague of mine, Chip Rombough, of the Hand County home health agency, located in Miller, SD, requested that I share his information with you. His per-beneficiary aggregate limit will be $1,612. This agency did not provide physical or occupational services or psychiatric nursing in 1993, and they also covered a much smaller geographic area.

They, too, responded to the Governor's privatization policy. Their cost of services today is only $4 higher than it was in 1993. However, they have estimated a 24 percent reduction in Medicare reimbursement. This becomes even more problematic, as they are operating in the blind under IPS since January 1998, and the final IPS limits have not yet been published.

With IPS in effect as it stands, the VNA and Hand County agencies face serious financial difficulties, such that it may be necessary to limit our geographic area and discontinue the provision of high-cost, lower volume services, such as our therapies and psychiatric nursing. In the worst case scenario, agencies with low costs, such as the VNA and Hand County, may have to dissolve. If that occurs, there will be no access to home care in those rural counties that I have lifted out for you today.

Another major issue in Sioux Falls is the emergence of the new home care agencies. These agencies will receive the median of the national reimbursement instead of the formula which uses agency-specific data. We estimate that will be somewhere between $3,000 and $3,900.

I would ask you to please consider the inequity that is present when a longstanding community agency such as the VNA must compete with new agencies who do not have to be as cost-effective. Under IPS as currently enacted, new agencies entering the Sioux Falls market will have a per-beneficiary limit which is 146 percent higher than the Sioux Valley Hospital Visiting Nurses Association. It is simply not rational to consciously create that kind of inconsistency in Federal reimbursement for the same service in the same market.

We would hope that Congress would consider some of the concepts we understand are being proposed by Senator Collins and others. While we do understand the seriousness of the budgetary problems faced by Medicare, we sincerely believe that the negative effects of the home health IPS cannot be left unaddressed.

Thank you.

[The prepared statement of Ms. Slack follows:]

Sioux Valley Hospital Visiting Nurses Association

Home Health Interim Payment System and its Impact in Rural South Dakota

Introduction

I'm Cindi Slack, the Executive Director of the Sioux Valley Hospital Visiting Nurses Association. The Visiting Nurses Association of Minnehaha County was founded in 1966 by interested community members from Sioux Falls, South Dakota who identified the need for access to a Medicare Certified Home Health Agency. In 1996, the Board of VNA identified a need to connect with a hospital system to ensure their long-term survival. In January of 1997, Sioux Valley Hospital acquired governance of this agency.

Message

The Visiting Nurses Association is and has been one of South Dakota's lowest cost providers for many years. According to our calculations, under the Interim Payment System, on May 1, 1998, the beginning of our fiscal year, the VNA's per beneficiary aggregate limit will be $1,585.00 which is significantly lower than our actual costs which are already extraordinarily low. Additionally, sources at NAHC and VNAA have indicated to me that this per beneficiary aggregate limit is the lowest limit in the country that they have seen to date. This is well below any State or Region census division reimbursement per person (see chart). The effect of the Interim Payment System essentially punishes those agencies that have historically been low cost providers and rewards those agencies with extremely high costs.

Statistics

Our agency currently provides on average 34 visits per patient. Our State average is 39.2 visits per patient served. The national average is 75 visits/patient (1995 data). Our current cost is $77.00 per nursing visit. The national average cost per patient for nursing in 1997 was $98.00. In calendar year 1993, our cost was $74.76 per nursing visit. The significance of that change is that our cost per visit increased less than one-half of one percent annually from 1993 to 1997.

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Events of Historical Significance

Further details one should be aware of is that the profile of the Visiting Nurses Association in 1993 was one of a provider whose primary service was skilled nursing and home health aide visits. Very few physical therapy or occupational therapy visits were made and there were no speech therapy, medical social work or psychiatric nursing visits.

Additionally, the VNA of Minnehaha County served only the residents of Minnehaha County. In 1997, the VNA acquired the Lincoln County Home Health Agency and began providing services from Sioux Falls to our Iowa border through a branch in Vermillion, South Dakota.

Since 1993, much has changed in the State of South Dakota. Not only have home health agencies been effected by the decreased length of stay of patients within the hospital or institutional environments, but our State was also effected by a policy decision of our Governor, William Janklow. That policy decision privatized home health. As a result of the privatization of home health services, the State of South Dakota ceased to employ nurses to provide skilled nursing services under the Medicare Home Health Benefit and terminated the Statewide coverage of its Medicare Home Health Agency. As a result of that, the counties noted on my map (enclosed) of Brule and Lyman had no home care provider. The Visiting Nurses Association met the needs of that population and expanded to provide services in a branch office located in Chamberlain, South Dakota. This branch office now facilitates not only the skilled nursing services for those two counties, but also facilitates the public health function for those counties along with the WIC Program. Additionally, there were significant and costly changes for the VNA. There are no other providers in Brule and Lyman County. The shaded areas on the map are indicative of two of South Dakota's Indian reservations. Our VNA also serves the Native American population for skilled services that would not be normally provided by Indian Health Services.

Other Rural South Dakota Agencies

I'd also like to reflect on one of my colleagues' data. The issue of the interim payment system is not only of concern to the Visiting Nurses Association in Sioux Falls, South Dakota which serves the Chamberlain and Vermillion areas, but it is also of concern to many of the other rural areas of our State. In a discussion with Chip Rombough, who is the Executive Director of the Hand County Home Health Agency based in Miller, South Dakota, (see attached map) he asked me to share this data with you:

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- Their per beneficiary aggregate limit will be $1,612.00. **(In 1993 this agency did not do PT, OT and Psychiatric Nursing and they covered a smaller geographic area. They expanded their geographic area as a part of Governor Janklow's privatizing of home health services).**

- Currently, the cost of services in 1997 was $4.00 higher than the cost of services provided in 1993.

- The majority of clients who are served are women, 85 years and older with comorbid health conditions who are living alone and whose families are located far away.

- In 1993 the average visits per client were 24 and in 1996 were 44.

- Weather creates major increases in cost as staff travels all over Hyde and Hand County.

- Approximate financial loss this year will be $73,000. This is a 24% reduction in Medicare reimbursement. This became even more problematic as this agency has been operating under the IPS limits and the final IPS per beneficiary limits have not yet been published.

- Consideration is being given to the following action plan:
  1st - Discontinue high cost services such as PT, OT and psychiatric nursing.
  2nd - Decrease the geographic area covered.
  3rd - Decrease by half the number of visits/beneficiary. This will severely restrict access to services in this area.
  4th - If something does not change to increase revenue within the 1998 calendar year, discontinue providing home health as of January, 1999.

Significance

If the Interim Payment System goes into effect as it stands, the VNA and Hand County Home Health agencies face serious financial difficulties, such that it may be necessary to limit our geographic coverage area or discontinue the provision of specific services such as physical therapy, occupational therapy, etc. In the worst case scenario, agencies whose costs have been historically low such as the VNA may have to dissolve. Should these agencies be dissolved there are no providers in our rural counties of Hand, Hyde, Brule, Lyman and Buffalo County. Therefore there will be no access to home health services in this rural area.

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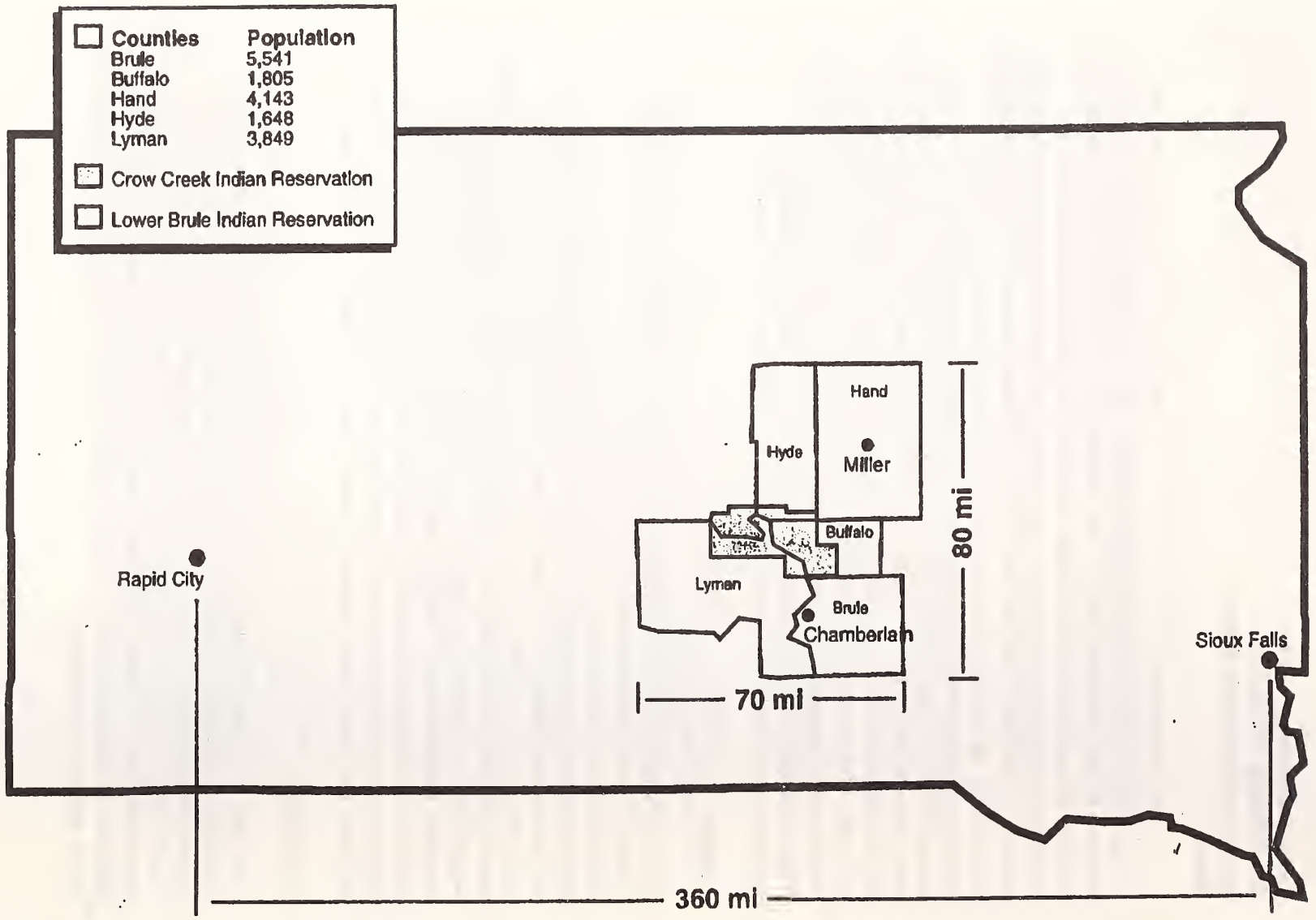
At this time I would call your attention to Sioux Falls, South Dakota and the Visiting Nurses Association parent agency in that community. Not only are we the lowest cost provider in our City, but we have had market penetration in our community by an emerging number of new agencies. As a result, if the Interim Payment System goes into place as it is currently planned, then the Visiting Nurses Association will also be effected by the ability of the two newest agencies who will receive the national median reimbursement instead of reimbursement which uses agency specific data, which in our estimation will be somewhere around $3,900 per patient. Please consider the inequity that is present when a long-standing community agency must compete with new agencies who do not have to be as cost effective as the agencies that have been in existence for a long time. Under the Interim Payment System as currently enacted, new agencies entering the Sioux Falls market will have a per beneficiary limit which is 146% higher than Sioux Valley Hospital VNA. It is simply not rational to consciously create that kind of inconsistency in Federal reimbursement for the same service in the same market.

Solution

The solution to this problem is complex and technical. The optimal solution for the Visiting Nurses Association would be to repeal the IPS and allow HCFA to work aggressively on implementation of the prospective payment system for October 1, 1999 implementation, and to carefully examine the effect of the prospective payment system on cost-effective agencies. The second best solution would be to either leave cost-effective agencies under the current cost limits and not subject them to the per beneficiary annual limit, or to create some sort of blending of national and regional limits which would then level the playing field for the cost-effective agencies. Additionally, we would hope that Congress would consider some of the concepts we understand are being proposed by Senator Collins and by Senator Kennedy. We understand the seriousness of the budgetary problems faced by Medicare, but we sincerely believe that the negative effects of the Home Health Interim Payment System cannot be left unaddressed.

Conclusion

The Interim Payment System has been evidenced to have serious inequities as home health agencies begin to calculate their rates of payment and assess the impact. If unchanged the Interim Payment System will severely restrict home care services for South Dakota senior citizens especially in rural areas. The effects of the Interim Payment System can be felt in agencies in South Dakota and other areas where the conservative approach to management of services has already created a cost-effective environment in which home care is practiced.


Counties Population
Brule 5,541
Buffalo 1,805
Hand 4,143
Hyde 1,648
Lyman 3,849
Crow Creek Indian Reservation
Lower Brule Indian Reservation
Hand
Hyde
Miller
Buffalo
Lyman
Brule
Chamberlain
80 mi
70 mi
Rapid City
Sioux Falls
360 mi

Prepared by NAHC

Census Division Reimbursement Per Person in Calendar Year 1994

State/Region	Reimbursement Per Person	Reimbursement Per Visit	Visits Per Pason Served
US+outlying areas	$3,987	$60.69	65.6
New England	$4,023	$52.60	76.4
CT	$4,367	$59.86	72.9
ME	$3,365	$52.54	64.1
MA	$4,328	$49.69	87.0
NH	$2,823	$49.75	56.8
RI	$3,753	$61.64	60.7
VT	$2,635	$43.56	61.4
Middle Atlantic	$3,031	$70.39	43.0
NJ	$2,702	$68.07	39.7
NY	$3,334	$74.70	44.6
PA	$2,899	$67.30	43.0
East North Central	$3,272	$63.43	51.5
IL	$3,386	$65.42	51.9
IN	$4,000	$55.16	72.5
MI	$3,285	$73.38	44.7
OH	$3,014	$59.44	50.7
WI	$2,586	$62.18	41.6
West North Central	$2,871	$61.19	46.9
IA	$2,280	$49.10	46.4
KS	$3,486	$62.27	55.8
MN	$2,518	$66.59	37.8
MO	$3,161	$63.78	49.5
NE	$2,566	$62.72	40.9
ND	$2,380	$57.36	41.5
SD	$2,402	$60.62	39.2
South Atlantic	$4,066	$58.74	69.1
DE	$2,478	$56.78	43.4
DC	$3,462	$82.03	42.1
FL	$4,595	$60.54	75.9
GA	$5,215	$50.97	102.1
MD	$2,859	$76.84	37.1
NC	$3,287	$57.32	57.3
SC	$3,764	$56.35	66.8
VA	$3,168	$64.38	49.0
WV	$2,819	$55.07	51.0
East South Central	$5,329	$50.42	105.7
AL	$5,107	$44.92	113.4
KY	$3,369	$52.05	64.8
MS	$5,316	$46.79	113.5
TN	$6,508	$55.84	116.4
West South Central	$5,877	$57.51	102.1
AR	$3,586	$47.14	76.0
LA	$6,700	$53.19	125.8
OK	$6,035	$57.04	105.7
TX	$5,977	$61.36	97.4
Mountain	$4,050	$63.52	63.7
AZ	$3,932	$70.00	56.2
CO	$4,091	$68.38	59.8
ID	$3,347	$61.92	54.2
MT	$3,052	$59.37	51.6
NV	$4,466	$65.62	68.1
NM	$3,355	$60.03	56.0
UT	$5,481	$55.46	98.4
WY	$4,309	$56.00	77.0
Pacific	$3,862	$86.84	44.5
AK	$4,336	$99.28	43.4
CA	$4,075	$88.39	46.1
HI	$3,549	$85.79	41.0
OR	$3,188	$80.75	39.7
WA	$3,951	$79.46	38.4
Outlying	$1,658	$45.24	36.6

Source: Health Care Financing Administration, Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 1996

Prepared by NAHC

Calculations of Cost Limits, Per Beneficiary Limit, and Reimbursement
NAHC - Modeling Reimbursement Under the New Interim Payment System (8/15/97)
Limits, update factors, & census division data are estimates subject to change.

Estimated Per Visit Cost Limits	RURAL Estimated National Limit	Labor Portion 77.6684%	Labor Portion w/Wage Index	Labor Portion w/Budget Neutrality	Non-Labor Portion	Total Labor & Non-Labor	Estimated Cost Limit w/cost rpnt adjust
Adjustment Factors			0.8620	1.076			1.0027
Skilled Nursing	$96.36	$76.39	$65.85	$70.99	$21.97	$92.96	$93.21
Physical Therapy	$105.57	$81.99	$70.68	$76.19	$23.58	$99.77	$100.04
Occupational Therapy	$111.84	$86.86	$74.87	$80.71	$24.98	$105.69	$105.98
Speech Pathology	$110.17	$85.57	$73.76	$79.51	$24.60	$104.11	$104.39
Medical Social Service	$149.87	$116.40	$100.34	$108.17	$33.47	$141.64	$142.02
Home Health Aide	$42.33	$32.88	$28.34	$30.55	$9.45	$40.00	$40.11

Calculation of Agency-Specific Per Beneficiary Annual Limit

1994 Total Medicare Visit Costs	$388,822.00
1994 Total Cost Limit	$550,037.00
1994 Total Reasonable Visit Cost	$388,822.000
1994 Total Medical Supplies	$15,194.00
1994 Total Reasonable Cost	$404,016.00
1994 Unduplicated Medicare Patients	398
Avg. Cost per Medicare Patient	$1,015.12
98% of Avg. Cost per Medicare Patient	$994.81
Market Basket Update	1.0938
Updated Avg. Cost per Patient	$1,088.13

	Census Division	Agency-Specific	Agency Blended Limit
Census Division Avg. Cost per Pt.	$2,871.00		
98% of Census Division Avg Cost/Pt.	$2,813.58		
Market Basket Update	1.0938		
Updated Census Division Avg. Cost/Pt.	$3,077.49	$1,088.13	
Blend	25%	75%	
Agency Blended Limit	$769.37	$816.10	$1,585.47

1994 Base Year Information	1994 Cost per Visit	1994 Medicare Visits	1994 Avg. Visits/Pt.
Skilled Nursing	$74.90	4,117.0	10.34
Physical Therapy	$75.19	193.0	0.48
Occupational Therapy	$74.33	3.0	0.01
Speech Pathology	$70.38	18.0	0.05
Medical Social Service	$87.18	0.0	0.00
Home Health Aide	$22.39	2,874.0	7.22
Total		7,205.0	18.10

Estimating Reimbursement for FY beginning on or after 10/1/97 Using Agency Projections

Projected Unduplicated Medicare Pts.	700
Aggregate Per Beneficiary Limit	$1,109,829.00

	Projected Cost per Visit	Projected No. of Visits	Projected Avg Visits/Pt.	Projected Cost per Discipline	Estimated Cost Limit	Projected Cost Limit Per Discipline
Skilled Nursing	$50.00	7,000	10.00	$350,000.00	$93.21	$652,470.00
Physical Therapy	$50.00	1,000	1.43	$50,000.00	$100.04	$100,040.00
Occupational Therapy	$50.00	286	0.41	$14,300.00	$105.98	$30,310.28
Speech Pathology	$50.00	20	0.03	$1,000.00	$104.39	$2,087.80
Medical Social Service	$50.00	256	0.37	$12,800.00	$142.02	$36,357.12
Home Health Aide	$20.00	4,900	7.00	$98,000.00	$40.11	$196,539.00
Total		13,462	19.23	$526,100.00		$1,017,804.20
Medical Supplies				$22,000.00		$22,000.00
Total Visit & Medical Suppy Cost				$548,100.00		$1,039,804.20

		Per Patient
Reimbursement	$548,100.00	$783.00
Total Cost	$548,100.00	
Breakeven (Loss)	$0.00	

Note: This information can only be considered for illustrative purposes due to the limitations of the estimates

1996 South Dakota Population Estimates age by Gender

Brule	TOTAL		
	Male	Female	TOTAL
Under 5	204	204	409
5-9	276	246	522
10-14	337	292	629
15-19	223	175	398
20-24	120	113	233
25-29	155	146	302
30-34	179	195	373
35-39	218	175	393
40-44	177	164	341
45-49	119	156	275
50-54	141	136	277
55-59	115	124	239
60-64	114	121	235
65-69	128	129	256
70-74	109	112	221
75-79	74	97	171
80-84	47	88	136
85 & Over	42	89	132
TOTAL	2,779	2,762	5,541

17% of Total

Buffalo	TOTAL		
	Male	Female	TOTAL
Under 5	119	109	227
5-9	137	97	234
10-14	147	112	259
15-19	88	77	165
20-24	65	53	119
25-29	61	50	102
30-34	60	66	127
35-39	56	36	92
40-44	46	50	97
45-49	46	48	97
50-54	33	43	75
55-59	23	24	46
60-64	22	24	45
65-69	27	26	52
70-74	12	20	32
75-79	15	9	24
80-84	2	5	7
85 & Over	2	2	4
TOTAL	954	851	1,805

7% of Total

1996 South Dakota Population Estimate Age by Gender

Hand	TOTAL		
	Male	Female	TOTAL
Under 5	121	137	258
5-9	167	144	311
10-14	170	182	352
15-19	160	133	293
20-24	89	66	155
25-29	108	95	204
30-34	121	118	239
35-39	151	141	291
40-44	128	128	256
45-49	120	122	242
50-54	113	107	220
55-59	103	124	227
60-64	120	121	241
65-69	116	120	236
70-74	105	103	209
75-79	69	80	149
80-84	47	86	133
85 & Over	33	93	127
TOTAL	2,043	2,100	4,143

Hyde	TOTAL		
	Male	Female	TOTAL
Under 5	53	50	102
5-9	66	61	126
10-14	59	79	138
15-19	42	46	87
20-24	22	24	46
25-29	42	40	81
30-34	53	51	103
35-39	59	57	125
40-44	52	40	91
45-49	37	35	71
50-54	43	58	100
55-59	49	43	91
60-64	43	42	84
65-69	36	45	80
70-74	49	53	101
75-79	35	50	84
80-84	26	47	72
85 & Over	13	49	62
TOTAL	783	865	1,648

1996 South Dakota Population Estimates Age by Gender

Lyman	TOTAL		
	Male	Female	TOTAL
Under 5	184	153	338
5-9	162	190	352
10-14	213	203	416
15-19	166	132	297
20-24	93	86	179
25-29	117	95	212
30-34	145	128	273
35-39	135	119	254
40-44	131	132	262
45-49	89	116	205
50-54	99	93	191
55-59	92	102	193
60-64	82	82	165
65-69	60	69	129
70-74	73	85	158
75-79	66	49	115
80-84	26	36	62
85 & Over	20	28	47
TOTAL	1,950	1,899	3,849

14% of Total

The CHAIRMAN. Go ahead, Mr. Martin.

STATEMENT OF DAVID J. MARTIN, ADMINISTRATOR AND CO-OWNER, APPLE HOME HEALTHCARE, INC.; AND CO-OWNER, METRO PREFERRED HEALTH CARE, INC., METAIRIE, LA

Mr. MARTIN. Good morning, Mr. Chairman, Senators and staff. I am David Martin, administrator and co-owner of Apple Home Healthcare, and also co-owner of Metro Preferred Health Care. Both agencies provide home health services in the metropolitan New Orleans area.

I ask that my written statement be submitted for the record. I will now briefly summarize my written testimony.

While honest providers acknowledge that reform is necessary, we must be very careful to not adversely affect legitimate providers and the patients they serve. The current interim payment system has some urgent problems that need to be immediately addressed.

The two topics of my discussion are: inequities in the per-beneficiary limit for agencies in the same market, and the proposed requirement that all new providers are to be reimbursed using the national average per-beneficiary limit.

First, disparity in PBL's for agencies in the same market creates a distinct and severe competitive disadvantage for the low-cost old provider, as well as for new providers, in that same market. Older, high cost, inefficient agencies are rewarded for being inefficient under the current IPS, and are offered no incentive to change. How are the older, efficient agencies and the new providers supposed to compete with the high-cost agencies when the inefficient agencies' PBL can be two to three times higher than that of his competitors?

In February of this year at Metro Preferred, we lost three office staff and five field nurses to one of our competitors. Upon exit interviews with these staff members, it was learned that our competitor used its high PBL as a recruiting tool. They told these employees that, regardless of what happens in the industry, they would survive because of their agency-specific PBL of $13,000.

To make matters worse, this company offered the staff members salary increases of up to 30 percent more than what they were currently earning, because they had more leeway in their PBL. How are the low-cost old providers and the newer providers supposed to compete with this?

Ultimately, the low cost and new providers will give way to the high cost agencies. Where are the patients of the defunct agencies supposed to go for care? These patients will be forced into traditional, more expensive settings for care, such as hospitals and nursing homes. The current IPS assures that we will end up with the very people that Congress and HCFA are trying to rid from the program, the highest cost providers.

The second point that I would like to bring out is that of imposing a national average PBL to all the newer agencies across the Nation, regardless of census region. This concept is flawed because the PBL creates an undue hardship on new providers and their patients in some regions, while providing an unfair competitive advantage for new providers in other regions. The regional PBL's should be used because they take into account demographic difference in patients, such as community resources, State Medicaid

programs and requirements, education, poverty and community health issues. Forcing the national average on agencies in different regions creates an access to care problem because the complex cases, which are the sickest, most frail patients, will not be able to be admitted for care.

At Apple we recently had a wound care referral that called for sterile dressing changes twice daily. Upon evaluation of the case, it was apparent that the cost of this patient's care could run in excess of $12,000. In anticipation of having to comply with the national PBL, which is estimated at roughly $4,000, we had to forego admitting the patient. This is not how home care is supposed to work. Where is this patient supposed to go for care?

Quality of care is also an issue. The agencies that do admit these costly, complex cases are still going to have to employ cost containment measures. These agencies will have to cut corners in the way that they treat these patients in order to be able to afford to keep the patient on service. Why should the patient's quality of care be compromised in order to fit a generic reimbursement model?

In conclusion, I recommend giving agencies in the same competing market the same PBL. Let agencies compete head-to-head on a level playing field and the program will end up with the most efficient, most effective providers.

Also, the census region PBL, not the national average PBL, should be used. This would better reflect patient needs in any given area. Using the census region will also help to alleviate the quality of care issues of patients and make it more feasible for agencies to accept the difficult cases.

I am appreciative of having the opportunity to speak to this important topic. Seldom does an issue present itself which has outstanding potential to improve the delivery of health care to Medicare seniors, while at the same time hold dire circumstances for an industry and its patients.

The deciding criteria for success or failure lies in the minutia of legislation, regulation, and implementation. I encourage your diligence in fashioning a solution that is fair and equitable to all stakeholders.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Martin follows:]

Apple Home Healthcare

Medicare Equity in the Interim Payment System Emerges As Crucial Issue for Home Health Recipients

Senate Special Committee on Aging

Dirksen Senate Office Building
Room 628

March 31, 1998

10:00 a.m.

INTRODUCTION

I am David Martin, Administrator and co-owner of Apple Home Healthcare Inc., a Joint Commission Accredited home health agency and, also, a co-owner of Metro Preferred Health Care, Inc. Both agencies deliver home health service in the metropolitan New Orleans area. Apple is a member of the Homecare Alliance of the South, Inc. (HAS) which is a not-for-profit organization representing over 30 independently owned agencies located throughout Louisiana. I have consulted with HAS' Director, Steve Freeman, in drafting testimony that is reflective of my problems as well as problems of other members of the alliance.

MESSAGE: INEQUITIES IN THE CURRENT INTERIM PAYMENT SYSTEM

While there are many important issues that presently face our industry such as surety bond requirements and the exclusion of venipuncture as a covered home health service I will focus only on one...the Interim Payment System (IPS). The message that I would like to leave with you today is that reform of the current IPS can help bring the desired cost savings to the Medicare program while still maintaining access to care and quality of care for Medicare beneficiaries. I realize that problems of fraud and abuse that are occurring nationally have been magnified in Louisiana because, for years, there were virtually no barriers to entry for the industry in our state. Previous unrestricted entry into

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the industry in Louisiana has produced an over saturated market of more than 500 home health agencies. In order for many of these agencies to maintain viability there has been rampant overutilization of services. While acknowledging that reform is necessary and welcomed by honest providers, one must be careful to not adversely affect the legitimate providers and their patients.

FAIRNESS AND EQUITY IN REIMBURSEMENT

Before addressing the issues concerning unequal reimbursement for home health agencies I would like to segment IPS reimbursement into two components. The first is the Per Beneficiary Limit (PBL) calculation that is performed on agencies that have submitted a twelve month cost report by the close of Federal fiscal year 1994. Agencies that meet this criteria will have their PBL set at the blended rate of 75% of their specific agency cost and 25% of the average agency cost in their respective census region. These agencies will be referred to as "old" providers. The second component is the PBL calculation for agencies that do not have a twelve month cost report as of the end of Federal fiscal year 1994. These agencies are slated to receive the national average PBL with no blend for their agency specific cost or their census region cost. These agencies will be referred to as "new" providers.

The current IPS is plagued with inequity in reimbursement by having different PBLs for agencies. This problem exists not only for "old" versus "new" agencies but also for competing "old" agencies that had completely different cost structures in the 94 base year.

Presently, efficient "old" providers or a "new" provider using the estimated national PBL of $4,000 is forced to compete with the inefficient "old" provider who may have a PBL of more than 2 to 3 times the national average. These agencies are serving similar patients and are drawing from the same wage and labor markets. It is apparent that the high cost provider has a distinct competitive advantage over the lower cost provider.

In February of this year I lost three office employees and five caregivers to a competing agency. Upon exit interviews with these staff members it was discovered that my competitor touted its PBL of $13,000 as a recruiting tool. These employees were told that no matter what happened in the industry their agency would survive because of the high PBL. These same employees were offered salaries ranging from 15 - 30% more than what they were currently earning because this agency had such a high PBL. How can efficient providers with a PBL at or near the national average recruit and retain quality staff?

The inequities in the PBLs affect more than just the low cost providers. They affect the beneficiaries as well. While reaffirming that the market could sustain some level of shakeout without interfering with patient care in Louisiana, the effect of IPS would jeopardize the viability of substantially all of the "new" providers. In Louisiana this would account for 67% of home health agencies. This drastic reduction of providers would create a patient access to care problem as there would not be enough agencies to provide care to all patients that qualified. Eventually, these patients would end up in the

highest cost institutions for care such as hospitals and nursing homes. Any savings realized by the decrease in the number of home health visits would be more than offset by the added expense of having these patients cared for in traditional settings.

Another unintended result of having different PBLs for agencies in the same market is that after the shakeout is over the only agencies remaining will be the highest cost providers. These new mega-agencies would flourish through attrition and would help to erode and negate any savings that had been hoped for in the implementation of IPS.

ONE RATE PER REGION: EQUATING PAYMENTS WITH POPULATIONS

The proposed concept of using the national average PBL for the entire country is flawed. Forcing agencies to use the national average in their respective region will create undue hardships on agencies and patients in some areas while promoting excess utilization and reimbursements in others. Using the national average fails to take into account regional abberrances which result in different costs per beneficiary across the country. Factors that need to be considered are availability of community resources to patients, state Medicaid programs and requirements, poverty, education level, and community health issues. When considering these facts it makes more sense to use regional limits so as to better reflect the patients needs in that area.

Inaccurate reflection of patient demographics is not the only problem with applying the national average across the country. It also has a negative effect on beneficiaries that have the most intense and complex cases. These patients are our sickest, most frail citizens. These costly patients will be denied access to home care services as agencies will be at a financial disadvantage if they accept the case. The agencies that do admit these tough cases will be forced to "cut corners" in their delivery of care in an effort to control costs. It is inevitable that the quality of care for these patients will be diminished.

In an effort to keep case cost close to the national average, John Fontana, a member of HAS and the owner of Audubon Home Health, was investigated last Tuesday by the Department of Health and Hospitals in response to a patient complaining of reduction of utilization. The surveyor found that Audubon's actions had been appropriate and there was no further action taken by the state. This is one isolated instance of a much larger problem of patients' level of care being adversely affected by the national PBL.

At Apple we have already had to make tough choices before admitting patients. We were recently faced with a situation which involved a wound care referral who needed sterile dressing changes twice a day. We knew that the cost of care for this patient could easily run in excess of $12,000. In light of being saddled with the national limit we could not accept the case. This is not how home care is supposed to work. Where are these patients supposed to go to receive care under the IPS system... Medicaid, Hospitals, Nursing homes?

PER BENEFICIARY EFFECTIVE DATE: OPERATING IN THE DARK

Perhaps one of the most bizarre twists of the IPS is that the effective date of the system was October 1, 1997 but the PBL is still unpublished. Even though the limit is due out tomorrow, many agencies nation wide have been operating without knowing what their reimbursement level will be. This has created a huge operational dilemma. What level of care am I able to provide for my patients and still be assured that I won't be faced with an overpayment at the year's end? How do I compete with "old" providers who already know what their limit is?

Lauren Glonek, another member of HAS and the owner of Excelcare Home Health, has already been forced to take drastic action on this issue. In fear of not knowing where her agency needed to be cost wise, she was forced to reduce caregivers rates by an average of 12%. She also reduced all office staff salaries including her own by 10%. Even though Excel's own per beneficiary cost is lower than the PBL in its census region, layoffs were necessary to avoid a potential overpayment at year end if the national PBL were applied. Good, diligent, high performing employees were laid off in order to help bring the overhead more in line with the worst case scenario of the national PBL. This same situation is being played out by low cost providers across the nation. The issue of operating blind has played squarely into the hands of the higher cost "old" providers because of the simple fact that they have more leeway and need not be concerned about the PBL.

As in previous examples, what affects the home health agency also affects the patients of that agency. Besides controlling costs internally to combat operating in the unknown, agencies are also being forced to reduce services to beneficiaries. Again, reduction in services is being relied upon to help assure that the provider will not be in an overpayment situation once the final limits are published. This too is playing into the hands of the higher cost providers as they can not only maintain the current level of care but can, in many instances, increase the number of visits the patient is receiving. The patients on service at the low cost or "new" agencies will end up in one of a finite number of places... the high cost or "old" provider or back into a traditional institution.

SOLUTIONS

- Implement the same PBL for all agencies in a given region regardless of agency specific base year cost or "new" or "old" status. This will allow all agencies to compete on a level playing field and would achieve HCFA's goal of being left with the most efficient providers.

- Use the regional PBL instead of the national to allow for differences in patient demographics and regional aberrances.

- Postpone the effective date for IPS until October 1999 in order to allow agencies time for a proper transition. Have the same rate for agencies in a given region take effect at the same time.

CONCLUSION

I am appreciative of having the opportunity to speak to this important topic. Seldom does an issue present itself which has outstanding potential to improve the delivery of health care to Medicare seniors while at the same time hold dire circumstances for an industry and its patients. The deciding criteria for success or failure lies in the minutia of legislation, regulation, and implementation. I encourage your diligence in fashioning a solution that is fair and equitable to all stakeholders.

The CHAIRMAN. Mr. Dombi.

STATEMENT OF WILLIAM A. DOMBI, VICE PRESIDENT FOR LAW; DIRECTOR, CENTER FOR HEALTH CARE LAW, NATIONAL ASSOCIATION FOR HOME CARE

Mr. DOMBI. Thank you, Mr. Chairman, Senator Breaux. I appreciate the opportunity to speak with you today. My name is Bill Dombi and I'm with the National Association for Home Care.

I personally have been involved in Medicare home care issues for nearly 25 years, and never in that time have I seen such monumental changes as we've seen this year, changes with the interim payment system, the surety bond, and the venipuncture provision.

We have the utmost of respect for HCFA, its officials, its staff. They are well-intentioned, hard working people, trying to do the best job they can in a very difficult time. But to characterize the interim payment system as a bridge to the prospective payment system is not accurate. If it's a bridge, there is a long span that's missing. Right now we have home care patients and providers, both falling into the river as a result of that span missing.

It is a concept, as I mentioned, that is well-intentioned, but flawed. It looks towards the case mix of an agency 5 years ago and assumes that it continues the same today in 1998. As mentioned by earlier witnesses, that is not the case. We have nearly 5,000 new home health agencies operating in the Untied States since 1993. Things have changed and the system does not account for that.

The only good system is a system that accounts for the case mix of the agency, the variation in the costs of treating one type of patient from another. The hospitals have that system, the physicians have that system, and home care needs that system as well.

The sickest of patients are being hurt. It is not something which is just foreseeable; it's something which is happening today. Patients are being discharged from services because they are too costly. Patients are being refused services because they are too costly. The system is driven by incentives, and the incentive now is to reduce costs any way possible.

Prospective payment is the solution. We would certainly agree with Senator Breaux, that the best thing here would be to eliminate the interim payment system. It's a tough word to use. Whether you call it moratorium or repeal, but it's really the only true fix that's there.

You may not need the interim payment system to achieve the savings which was expected when the budget was analyzed last year. Expenditures in home health, even before the interim payment system, dropped significantly from what they had been projected at the time this Congress passed the interim payment system.

In 1997, expenditures were expected to be 19 billion for home health. The current calculation is that they are 17.5 billion for that year. That, alone, takes care of the savings that was expected in 1998 under the interim payment system. We will not have a home health system to use prospective payment if we continue along the path that the interim payment system has brought us so far.

We would then echo Senator Breaux's recommendation, that the system be eliminated, and that we move as quickly as possible to the prospective payment system. If that is not possible, there are options that we can look to—and we have put them in our written testimony, some recommendations.

But we think three principles need to be adhered to in whatever changes come about. First, it has to be simple; otherwise, it will not be put in place on time. Second, it has to be designed to protect the patient who is classified as a higher cost patient. We cannot disentitle the Medicare beneficiary to home health services through the reimbursement system and leave the scope of benefits, telling patients that they, in fact, are covered and third, in line with Mr. Martin's statement, the playing field has to be leveled. We cannot have home care agencies in the same town with disparate limits of $2,000 to $12,000. It just encourages the high-cost provider to continue in its existence.

Moving on to surety bonds, an area I knew nothing about last year. It's another shoe that doesn't fit. It's not an insurance for overpayments. It is intended to keep the bad guys out, and we want to keep them out as much as possible.

We continue to support the efforts of Senator Grassley and this committee in moving to create stronger standards for the enrollment of providers into the home health program. We have to have only the best and the brightest in the system. We do not want the people whose baggage we're now carrying for the last few years, those who committed fraud and abuse.

My last comment is on venipuncture. This is where you drop a bomb and then try to figure out what you've done. There were no studies, no analyses, no understanding of impact, before this provision was passed by Congress. There has been misinformation and continued statements which are not accurate as to the impact of this system. There are thousands of patients in this country today who were disqualified on February 5. They went into nursing homes; they went back into the hospitals because their conditions went sour.

We did not know how many, and we still do not know how many. And as the Administrator pointed out, she has no idea where you can get services from a lab to supplement this. She still cannot answer the question of what happens to 2.1 million Medicare beneficiaries who do not have Part B to cover the lab services. So we would encourage movement on Senator Shelby's bill to move this back into a moratorium, study it, and then take concerted action after we know what the impact may be.

Thank you.

[The prepared statement of Mr. Dombi follows:]

Mary Suther
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Honorable Frank E. Moss
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TESTIMONY

BEFORE THE SPECIAL COMMITTEE ON AGING

U. S. SENATE

MARCH 31, 1998

ON BEHALF OF THE

NATIONAL ASSOCIATION FOR HOME CARE

WILLIAM A. DOMBI
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Mr. Chairman,

Thank you for the opportunity to present testimony today on issues related to the Medicare home health benefit. My name is Bill Dombi. I am the Vice President for Law for the National Association for Home Care (NAHC) and Director of NAHC's Center for Health Care Law.

The National Association for Home Care is the largest national organization representing home health care providers, hospices, and home care aide organizations. Among NAHC's nearly 6000-member organizations are every type of home care agency, including nonprofit agencies like visiting nurse associations, for-profit chains, hospital-based agencies and freestanding agencies.

NAHC is deeply appreciative of the attention the Members of this Committee have shown to the problems created by the three home health provisions of the Balanced Budget Act of 1997 (BBA) which are the subject of this hearing: the home health interim payment system, surety bonds, and the exclusion of venipuncture as a qualifying service. We appreciate the opportunity provided by this Committee to express our concerns about the devastating impact these provisions are having on home health agencies and the patients they serve.

We have seen the arguments in favor of these BBA provisions, citing recent growth in the home care benefit and the need to curb home health utilization. It should come as no surprise, however, that home health care has expanded rapidly. A number of factors have played a role in this trend. Demographics show that the number of elderly and disabled is increasing. Hospital stays are becoming shorter, driven by cost controls. Nursing home use is declining. More patients and physicians are aware of home care. Technological advances are permitting more services to be delivered at home. Judicial rulings made home care more broadly and readily available. Finally, for most people, the home is the preferred setting for most health and supportive services. All of these factors have played a role in home care's increasing use and popularity. Given these many factors, we must guard against the temptation to attribute this growth to overutilization. To do so will lead to the loss of vital services for our elderly and disabled citizens.

The BBA cut home health spending by $16.2 billion over five years. Although home care represents only 9% of Medicare, it was slated for about 14% of the cuts in Medicare spending. Moreover, there is evidence to support the conclusion that the actual savings, if nothing is done to repeal or modify these three BBA provisions, may be over $40 billion due to Congressional Budget Office (CBO) scoring "offsets."

INTERIM PAYMENT SYSTEM

BBA made dramatic changes in the reimbursement system for Medicare home health services. These changes became effective for cost reporting periods beginning on or after October 1, 1997, and are intended to remain in effect until October 1, 1999, when a new prospective payment system (PPS) is implemented for cost reporting periods beginning on or after that date.

Under the new interim payment system (IPS), agencies are reimbursed the lowest of their (1) actual allowable costs; (2) aggregate per-visit cost limits; or (3) a new aggregate per beneficiary limit.

The purpose of IPS was to restrain the growth in home health utilization and limit the growth in expenditures. A number of significant problems have emerged which have led to results which, NAHC believes, were unintended by Congress in putting this system in place.

Reduced Cost Limits

IPS reduced the per-visit cost limits in two ways. First, the limits are calculated based on 105% of the median per-visit costs of freestanding home health agencies, rather than the previous method of 112% of the mean. Second, the new cost limits do not take into account the market basket price increases that occurred between July 1, 1994 and June 30, 1996. The combined effect of these two provisions represents a 21% reduction in the cost limits. The Health Care Financing Administration (HCFA) has estimated that 65% of all providers will be over these limits, as opposed to their estimation that 30% of providers would be over the limits in the previous year. NAHC believes that the percentage of those over the limits is even higher.

Problems With and Inequities Created by the New Per-Beneficiary Limits

In addition to the reduced cost limits, the new per-beneficiary limit has been of tremendous concern because of the inequities it creates. The per-beneficiary limit is a blended limit--75% agency-specific data and 25% census region data, with fiscal year (FY) 1994 as the base year. The idea behind the agency-specific component of the limit was that it would serve as a proxy for case-mix. The blend of census division data was intended to level the playing field, so that agencies within a census division with a lower cost per-patient than the census division would get a higher limit and agencies with a cost per-patient higher than the census division would end up with a lower limit. Census division data was used because there is significant variation in utilization in different areas of the country. So far, this variation has not been adequately explained, and there exists some evidence that usage is affected by the availability of Medicaid and other home and community-based alternatives in the area. Unless or until there is evidence that the regional differences in utilization reflect improper usage, it is important that regional differences be reflected in payment rates.

The primary impediment to developing a full PPS has been the lack of a case-mix adjuster to account for the characteristics of patients served that influence an agency's cost of providing services to those patients. Case-mix adjustment is necessary to ensure that agencies are not penalized for servicing a mix of patients whose care needs are more expensive and to eliminate the incentive for agencies to reject patients who require an unusually heavy burden of care. The theory behind the agency-specific component of the per-beneficiary limits was that an agency's own case mix would be the best predictor of the case mix of patients it would serve in subsequent years.

This concept works far better in theory than practice. Using FY94 as a base year means using 1993 data for a substantial number of providers with the result that payments are based on five-year-old data. Out-of-date payment levels do not reflect changes that have occurred in the population served by home care or the types of services agencies are providing in 1998, 1999, or beyond. Over this time period, there has been an increase in the number and percentage of higher-cost patients in the system.

There has also been a rise in the number of home health agencies, which further disperses patients. Referral patterns have also changed. Agencies which did not provide therapy services or medical supplies in the base year, but have subsequently provided these services, will have to determine how or even whether or not they can continue to provide these services. Further, there is no mechanism for providers or patients to appeal or request an exception to the limits.

The per-beneficiary limit has been an extremely divisive issue in the home care community because certain types of providers and certain geographic areas are affected differently by these limits. This problem is compounded by the treatment of "new providers." Under the BBA, new providers, those who do not have a full base year ending in FY94, are to receive the "median of these limits," which HCFA has interpreted to mean national averages, rather than census division limits. Since nearly one-half of all providers under this definition are new providers, this leads to inequitable results. Some new providers who deliver care in census regions with limits which are below the national average will have higher limits than existing agencies in the census division. In other areas, the opposite effect results. In Louisiana, we are told, one agency has a per-beneficiary limit estimated to be $3000 per year, and a competing agency in the same city has a limit of $13,000.

Many agencies that have been in existence for years that have worked to get their costs down and become more efficient in anticipation of a prospective payment system end up being harmed by the per-beneficiary limits calculation. They end up with lower limits, based on the agency-specific data, and are penalized for their own efficiency. This is a system that does not distinguish in any way between efficient and inefficient agencies and sets up serious competitive inequities.

Beneficiary Impact

The most devastating impact of the IPS, however, is on beneficiaries. IPS will significantly reduce access to home health services and restrict the level of care received by patients in their homes. The inadequacy of the new reimbursement limits leaves providers with the Hobbesian choice of restricting access to their services or financially destroying the organization by delivering care to patients that push the agency's operating costs above the reimbursement limits. Patients who need the most care are most at risk for cutbacks, or being denied access to care. These beneficiaries tend to be the oldest, sickest, poorest, and most frail Medicare beneficiaries. With lower Medicare payments, providers will have to cut back on staff, leaving them unable to care for all who need home care. Patients who need care the most will either not receive care, or will be cared for in more costly settings like emergency rooms, hospitals, and nursing homes.

It is important to note that although the reimbursement system has dramatically changed, the Medicare coverage criteria (except for the venipuncture exclusion) have remained the same. Providers will need to lower both their unit costs and their utilization of services in order to remain viable under IPS. Lowering either of these without adversely affecting patient care or the quality of services, however, may be extremely difficult.

Home health costs have grown much more slowly than both the health care market basket and the consumer price index (CPI). Therefore, it will be very hard for providers to reduce unit costs, continue to comply with quality standards, and stay under the cost limits.

Providers will also have to reduce utilization levels which could have a drastic impact on beneficiary care. One way to limit utilization is to cut the number of visits across-the-board to all patients. This could place some Medicare beneficiaries at risk since they will receive less care than they need to remain in the home. Lower utilization will also require family caregivers to carry a larger burden. Studies show that family caregivers already provide a majority of home care services. Under IPS, their burden will increase. Further, less visits mean higher costs per visit.

To lower utilization and costs, home care providers may be forced to selectively admit patients. Beneficiaries who require high-intensity services for a short period (e.g. infected wound patients who require two or three dressing changes a day) or long-term patients who require services over an extended period (e.g. a multiple sclerosis patient with limited skilled care needs, but who requires extensive home health aide services for help with activities of daily living) will no longer be desirable types of patients for home health agencies to serve. Without home care, these types of patients could end up with an increased number of acute-care episodes, thus increasing costs to Medicare, or end up in nursing homes at higher costs to state Medicaid programs.

This raises the issue of appropriate versus inappropriate discharges from care. HCFA has yet to come out with material to educate beneficiaries or to guide agencies, so NAHC has attempted to develop educational materials for both providers and beneficiaries. Our best efforts, however, cannot take the place of guidance from HCFA since this is an unclear area of the law which calls for official establishment of responsibilities. It is critical that providers understand how to appropriately discharge patients from service, should that be necessary. It is also vital that beneficiaries understand how IPS affects them and their home care benefits.

Publication of Per-Beneficiary Limits

It is also important to remember that the new per-beneficiary limits will not be published by HCFA until April 1998. These limits will be retroactive to October 1, 1997. This means that nearly 2/3 of all home health providers will have been on IPS before the actual limits are published. In effect, they have been "flying blind," making business decisions on educated guesses. It is no wonder that many agencies are behaving conservatively in terms of patient admissions because of fears that they will end up significantly over these new unknown limits.

Development of PPS

Under the BBA, HCFA is charged with developing a full PPS to be implemented October 1, 1999. HCFA has testified before Congress that they find this deadline "challenging." NAHC is concerned that they will not develop PPS by this deadline and that the IPS, with its serious flaws, will remain

in effect well beyond the two to three years it was intended to remain in place. Further, to the extent that HCFA must spend time and resources on IPS, it is further diverted from its task of developing PPS.

Reduction of Limits by 15%

On October 1, 1999, regardless of whether HCFA has developed PPS, home health expenditures are to be reduced by an additional 15%. This further reduction would be devastating to providers and would severely jeopardize the ability of beneficiaries to access care and restrict the level of care they could receive in their homes. The additional 15% reduction is unnecessary because the budget target will be achieved without it. Although the CBO estimated that the BBA would cut Medicare home care expenditures by $16.2 billion over five years, the reductions in per-visit cost limits and the per-beneficiary limits will likely cut home care expenditures by as much as $40 billion over the same period.

IPS Studies

Two recent studies on IPS echo many of the concerns that the industry has raised about the potential impact of IPS on beneficiaries and providers. A recent study commissioned by The Commonwealth Fund found that changes in Medicare payments for home health care resulting from the BBA have the unintended consequence of reducing access to services for the oldest, poorest, and sickest Medicare beneficiaries. These individuals tend to need the most home care, for the longest periods of time. The report also found that:

-IPS places new financial pressures on home care providers to reduce high volume, or longer-stay, episodes of care.

-Most longer-stay patients are not using the Medicare home health benefit solely or predominantly for long-term care. These individuals tend to have substantial acute care needs as well.

-The home care agencies most affected by IPS will not necessarily be the most inefficient. Agencies serving more patients with greater care needs than they served in FY94 will likely have difficulties maintaining the provision of appropriate care.

Another recently-released study by The Lewin Group, entitled "Implications of the Medicare Home Health Interim Payment System of the 1997 Balanced Budget Act" concluded that:

-The sickest and most fragile patients may have difficulty accessing services, experience reductions in service, or be shifted to less appropriate care settings as a result of the per-beneficiary limit, which is based on 1993-94 cost data.

-The IPS was enacted to restrain growth of the Medicare home health benefit. However, CBO's 1998 baseline indicates that growth in the benefit has already been restrained without the implementation

of IPS. The growth rate in home care for 1996 to 1997 sharply decelerated, changing from a projected 13.8% to only 4.8%.

-Agencies most affected by the new per-beneficiary limit include: 1) those that have had an increase in severity in their case mix since 1994; 2) small agencies serving a large number of high-use patients; 3) rural agencies where alternative sources of care are less likely to be available; 4) agencies that have added services since 1994, the cost of which will not be included in the per-beneficiary limit calculation; and 5) new providers and agencies resulting from mergers or acquisitions.

-The IPS requires agencies to hold down their costs without regard to past efficiency or current patient mix. Agencies that cannot make cost reductions in the short time frame will likely experience financial losses and potential closure.

Recommendations

The impact of IPS is so devastating that the ideal solution would be to repeal it and to require HCFA to meet its October 1, 1999, implementation date for a full PPS for home care. Absent a full-scale repeal, the following changes to IPS should be made:

1. Congress should delay the implementation of the per-beneficiary limits until fiscal year 1999.

2. Congress should change the base year from "12-month cost reports ending fiscal year 1994" to the 12-month cost reports ending in calendar year 1995. Congress should also change the per-beneficiary limit calculation in IPS from 98% to 100% of the base year cost per patient.

3. Congress should change the mandatory October 1, 1999, 15% reduction in the limits to a reduction of up to 15% based on the targeted expenditures for home health during that year.

4. Congress should allow the full market basket increase in calculating the per-beneficiary limits.

5. Congress should require that HCFA use the prorating provision only in situations where agencies are transferring or prematurely discharging patients for purposes of intentionally circumventing the limits.

6. Congress should extend authorizations for exemptions and exceptions to the per-beneficiary limits.

7. Congress should assign new providers a per-beneficiary limit that is the median of the limits for the census division where the agency is located.

8. Congress should, at a minimum, maintain periodic interim payments (PIP) until a prospective payment system for home health is enacted.

SURETY BONDS

Included in BBA was a requirement that each home health agency participating in Medicare and/or Medicaid secure a surety bond of at least $50,000, on a continuing basis. Agencies participating in both programs are required to secure two separate bonds. As members of the Committee are aware, the recommendation for this proposal came out of the Health and Human Services Inspector General's Office, based on the Florida Medicaid program's experience with a surety bond requirement for home health agencies and durable medical equipment suppliers.

However, the manner in which HCFA has sought to implement the federal requirement goes far beyond the Florida model, and provides a prime example of a situation where "more" is not necessarily "better." In fact, the two sponsors of the original surety bond legislation (Rep. Karen Thurman and Rep. Pete Stark) have expressed opposition to HCFA's implementation of the requirement, stressing that it goes beyond what Congress intended when it passed the BBA.

NAHC is fully supportive of efforts within Congress and HCFA to ferret out fraud and abuse and to prevent the admission of any unscrupulous provider into the home health care industry. The surety bond provision of BBA was intended to accomplish these ends. Since the enactment of BBA and the issuance of implementing regulations by HCFA, much has been learned by the home health industry, Congress, and the Medicare program relating to the surety bond concept. It now appears that these goals might be far better met through some other means. Standard qualifications for a surety bond relate to the profitability and financial standing of a business. However, Medicare and Medicaid home care services, the primary funding source for home care services nationwide, generally provide reimbursement at cost or less than cost and do not provide the financial foundation for the accumulation of assets. Nonetheless, a home care provider can be financially solvent and fully compliant with all Medicare and Medicaid requirements, thereby placing these programs at no risk. Even if the surety industry is capable of considering non-financial factors in qualifying an applicant for a bond, collateral and personal indemnification requirements will remain imposed upon an industry that will not have the capability of meeting those requirements.

NAHC believes that the best approach for Congress to take is a preventative measure rather than relying upon a surety bond as a fallback to correct mistakes which should have been avoided in the first place. The preventative measures come in the form of strengthened criteria for qualifying a home health agency as a provider of services. A home health agency should be afforded the privilege of serving Medicare and Medicaid patients only after it can demonstrate that it is capable of complying with coverage standards, reimbursement requirements, and the conditions of participation which are designed to protect the quality of care offered to patients. Currently, a prospective Medicare/Medicaid home health agency need only demonstrate compliance with the conditions of participation. Initial and ongoing evaluation of competency in the areas of reimbursement and coverage will provide far better protection for the Medicare and Medicaid programs than the use of a surety bond, which serves only to partially reimburse Medicare and Medicaid for mistakes long after they occur. NAHC is encouraged by the efforts of the Senate Special Committee on Aging to

establish these strengthened participation criteria and recommends that the committee continue this direction as a alternative to the ill-fitting concept of a surety bond.

HCFA issued interim final regulations to implement the home health surety bond requirement on January 5. However, there was such overwhelming objection to the regulations from individuals involved in the home health and surety industries that HCFA was forced to revamp the regulations. HCFA has announced three specific changes it intends to make -- all three of these changes respond to concerns raised by the surety industry and which have discouraged companies from writing bonds. Unless HCFA is prepared to make additional changes beyond those that have been announced, many reputable home health agencies will still be unable to secure bonds. It is unclear when the final regulation governing home health surety bonds will be available, but HCFA has stated that agencies will have 60 days after publication of the final regulation to secure bonds. Until that final regulation is published, it will be impossible to determine how many home health agencies will be unable to purchase bonds.

We do not believe that the Congress ever intended for the surety bond requirement to be so troublesome. Surety bonds were meant to serve as a deterrent to "fly by night" providers in Medicare and Medicaid -- to screen out entities that pose a significant risk to the integrity of the programs. HCFA has instead fashioned surety bond regulations that serve as an insurance against the loss of **any** program overpayments. Given that less than two-tenths of one percent of program revenues are unrecouped overpayments, this approach is unnecessary and onerous.

In Florida, agencies were required to purchase a bond of $50,000 in value; agencies in good standing with the Medicaid program that had participated for at least one year were permitted to forgo the requirement. In Florida, once a new agency has proven itself reputable, it no longer must purchase a bond. The federal bonding requirement, however, is continuous. HCFA has set the value of the bond at the greater of $50,000 or 15% of previous year's revenues from the Medicare and/or Medicaid programs. The minimum $50,000 amount can raise serious problems for the small, often rural, home health agency. Further, the 15% calculation could lead to a prohibitively high cost for a home health agency. At this level of bonding, HCFA appears to be establishing a level of protection needed only if every agency incurred the maximum potential overpayment and every agency failed to repay any part of the overpayment.

Some of the industry's concerns relate to the language used in the legislation itself. For example, the home care industry believes that it is appropriate for Medicare to recognize the cost of securing a surety bond. With current reimbursement to home health agencies based upon reasonable costs incurred in providing care, the failure to recognize the cost of a surety bond as allowable guarantees that Medicare services are provided at less than the cost of delivering the care. Further, since the concept of a surety bond acts as a participation screening device, the bond serves the purpose of the payor and not the provider. In operation, it acts as adjunct to the payors' qualification of a home health agency to participate. Accordingly, since it serves as a function of governmental administrative responsibility, the program should pay for the cost of the bond. This would be consistent with other government bonding arrangements.

While the absence of reimbursement for the bond cost causes great difficulty for the small HHAs, the greater concern is the likelihood of collateral or personal guarantee requirements at several times the bond value. Small HHAs faced with these requirements may not continue to operate. A similar concern exists in applying the bond requirement to Medicaid services. With low reimbursement rates nationwide the bond cost may discourage HHAs from continuing participation.

In applying the bond requirement, HCFA should also consider whether the home health agency is in good standing with the Medicare and Medicaid programs. HCFA has exercised its authority to establish a waiver of the requirement for government-operated home health agencies on the basis of a belief that the interests of the Medicare and Medicaid programs are adequately protected. A similar standard should be employed to apply to all types of home health agencies allowing an agency that has demonstrated ongoing compliance and fiscal responsibility to be eligible for a waiver or a reduced bond amount.

An additional concern is the potential that the surety company can become the payor of first resort rather than allowing the home care agencies to establish an appropriate repayment plan for any repayment. Bond companies are affected with this standard, as their risk of liability is substantially increased. Home care agencies are even more severely affected in that a payment under the bond would lead to the termination of the provider agreement even in cases where the home health agency is willing and able to make repayments.

HCFA must establish a standard which requires that the recoupment of an overpayment through their bond occurs only after fair and adequate opportunities are given to providers of services to enter into repayment plans. Currently, the program operates without any objective criteria for determining the eligibility of a provider of services to secure a repayment plan from the Medicare program. The lack of objective standards allows for an environment of arbitrary decision making. Further, the historical evidence of inappropriate intermediary determinations on claims and cost reports justifies the creation of a repayment plan system which allows home health agencies to pursue their appeals rights while repaying an alleged overpayment without risk of program termination.

The requirement that home health agencies obtain a separate bond each year dramatically increases the bond costs for home health agencies and correspondingly the bond company exposure. This cumulative or aggregate liability with resultant cost for the home health agencies renders the market for bonds inaccessible and the terms for qualification unmanageable. HCFA should allow for the existence of a continuous bond without risk of cumulative liability.

While the concerns relating to the January 5 regulatory issuance warranted HCFA's action to postpone the bond compliance date, clarification is needed from HCFA regarding the requirement that new providers secure bonds before being permitted to participate in Medicare and/or Medicaid. This standard particularly affects existing providers with branch offices that are transitioning to subunits under HCFA's August 1997 policy directive. These HHAs should be allowed to achieve provider status without the bond and fulfill the bond requirement consistent with the time standard that will be imposed on existing HHAs.

Finally, serious questions are raised in this rulemaking endeavor regarding the authority and appropriateness of waiver of the rulemaking protections available under the Administrative Procedures Act (APA). HCFA's failure to develop these regulations on a timely basis turn HCFA's explanation for waiver into a self-fulfilling prophecy. HCFA was well aware of the intent to move forward with a bonding requirement as part of the BBA. In fact, HCFA was an early proponent of the surety bond requirement, along with the Office of Inspector General. Accordingly, although the legislation was signed into law on August 5, 1997 there was more than sufficient time for HCFA to develop a proposed regulation for public review prior to its finalization. HCFA, however, chose to publish interim final rules on surety bonds for HHAs, while the surety bond rules for DME were published in proposed form. The steps taken by HCFA relative to the identical bonding requirement for durable medical equipment suppliers indicate that a reasonable interpretation of the law is available to pursue a proposed rulemaking route even with the January 1 effective date.

In addition, full compliance with the Small Business Regulatory Enforcement Fairness Act (SBREFA) of 1996, Public Law 104-121, does not appear to have been achieved with respect to HCFA's issuance of the surety bond regulations for home health. Under 5 U.S.C. § 801(a), the federal agency promulgating rules shall submit to each house of Congress and the Comptroller General a report containing a copy of the rule, a concise statement relating to the rule, including whether it is a major rule, and the proposed effective date of the rule before the rule can take effect. NAHC disagrees with HCFA that the surety bond rule does not represent a "major rule" under SBREFA in that the impact on small businesses is well in excess of $100 million. HCFA grossly underestimated the cost of the bond without adequate evidentiary backup and further failed to consider the financial impact on small businesses that would be forced to close and terminate Medicare provider agreements due to the inability to access a bond under reasonable terms sufficient to comply with the regulatory standards.

Similarly, HCFA failed to explore and evaluate alternative regulatory approaches and set forth reasons for rejecting or accepting them. Irrevocable letters of credit, committed liquid assets, and other alternatives should be explored as a means of providing the Medicare program with protections comparable to that available through the surety bond method. As a consequence of the failure to meet APA rulemaking requirements and the standards set in SBREFA, the promulgated regulations led to a crisis within the Medicare and Medicaid programs as few bond companies were willing to entertain consideration of the issuance of bonds and the vast majority of home health agencies failed to qualify or find access to any bond. HCFA should not proceed further with the implementation or enforcement of any final rules regarding a surety bond requirement until adequate opportunity for public comment occurs and compliance with the SBREFA is ensured.

General Recommendations:

1. HCFA should develop the surety bond regulations based on the intended principle and purpose of screening out inappropriate HHAs rather than as an insurance policy against overpayments.

2. Legislation should be enacted to allow recognition of the costs of a surety bond.

3. The bond amount should be reduced below $50,000 for small HHAs.

4. HCFA should reduce the bond amount to no greater than $50,000.

5. HCFA should establish standards for waiver of the bond requirement for any HHA in good standing.

6. HCFA should establish objective criteria for the eligibility of an HHA for a Medicare repayment plan.

7. HCFA should postpone the bond compliance date for new subunits so that it is consistent with the time standard for existing HHAs.

8. HCFA should modify the regulations to eliminate or limit any risk of cumulative liability for the surety.

9. HCFA should not implement or enforce the surety bond regulations until the completion of the notice and comment procedures under the APA.

10. HCFA should comply with all procedural requirements of SBREFA including Congressional notice and the exploration and evaluation of alternatives.

VENIPUNCTURE

Effective February 5, 1998 a provision included in the BBA removed blood drawing (venipuncture) as a qualifying service for the Medicare home health benefit. Prior to February 5, if a beneficiary needed venipuncture and met all other home health criteria, he or she could receive venipuncture from a home health nurse along with other Medicare-covered home health services ordered by his or her physician, including home health aide services. Under the new policy, if venipuncture is the sole skilled service needed, Medicare will only cover venipuncture provided by lab technicians under Part B, and homebound beneficiaries in need of blood monitoring will lose eligibility for home health services.

Beneficiaries qualifying for home health services based on venipuncture are some of the oldest and most disabled Medicare beneficiaries, many with multiple diagnoses including diabetes, heart disease, stroke and clinical depression. Many homebound individuals with chronic conditions and complex medication regimens will no longer receive nurse assessments for purposes of preventing acute episodes and hospitalizations. The home health aide services that are sometimes provided by the agencies in conjunction with blood monitoring make it possible for beneficiaries to remain in stable condition and at home. Without such services, many of these individuals may need to be admitted to long-term care facilities.

NAHC has received hundreds of phone calls and letters from consumers, physicians, providers, and other organizations raising concerns about the severe impact on patients resulting from the removal of venipuncture as a qualifying service under the Medicare program. Members of Congress have taken action and expressed their concern about the effects this provision is having on patients. However, HCFA has reported that they do not believe that Medicare beneficiaries were placed at risk as a result of this provision.

Impact of the Venipuncture Exclusion

HCFA has recently criticized home health agencies for alarming beneficiaries regarding the venipuncture exclusion. However, the reality is that thousands of Medicare beneficiaries have been denied care as a result of this change in the home health benefit.

Representative Robert Adherholt (R-AL) reported that in Alabama alone, between 15,000 and 20,000 venipuncture recipients were in jeopardy of losing their home care benefits. The Texas Association for Home Care estimated that about forty thousand Medicare beneficiaries in Texas would lose their home health benefits February 5 as a result of the elimination of venipuncture as a qualifying service. Projected to all Medicare-certified Illinois providers, an Illinois Homecare Council survey estimated 7,000 Medicare patients would be discharged after February 5, leading to higher utilization in skilled nursing or hospital facilities, and potentially higher utilization under the Medicaid benefit.

Dr. Don Williamson, who directs the state health department in Alabama, reported that a home health agency in his department dropped about one quarter of its 8,400 Medicare patients as a result of the venipuncture exclusion. When asked to comment on the new rule, he said, "I don't want to see thousands of elderly patients disenfranchised and end up in hospitals and nursing homes if they can be maintained at home...It troubles me that at a time when we're providing health insurance to uninsured children, old people are potentially losing a benefit they need." ("Thousands of Medicare Patients Losing Service," Anderson Independent-Mail, Anderson, S.C., February 11, 1998)

In an interview with Eli's Home Care Week, an official from one of HCFA's own Medicare fiscal intermediaries admitted, "a lot of people are going to fall through the cracks" as a result of the elimination of venipuncture as a qualifier. "Probably several things will happen," the official notes: these beneficiaries will end up in "an emergency room, a skilled nursing facility, or someplace worse like the mortuary. It is a cold cruel world, but the Medicare home health benefit will change effective February 5 and we don't want to see those services on a home health claim. After February 5, it's too bad, so sad." (Interview reported in Eli's Home Care Week, Volume VII, Number 5, February 2, 1998)

Limited Availability of Other Services As Qualifying Skilled Services

HCFA has stated that most of the individuals who currently qualify for Medicare home health benefits through venipuncture will still be covered because they have needs for other skilled services, such as management and evaluation or observation and assessment. However, the need for these skilled

services does not trigger a home health benefit sufficient in duration to meet the needs of most homebound venipuncture patients. Typically, Medicare covers these as separate skilled services for homebound venipuncture patients for only a few weeks until the patient stabilizes.

A March 10, 1998, letter received by NAHC illustrates this problem. An 85-year-old Medicare beneficiary in advanced stages of emphysema and congestive heart failure was discharged from home health on February 5 because her need for venipuncture no longer qualified her for the home health benefit. She was stable at the time of discharge. However, within a week she had to be transferred to the hospital in acute distress. She remained there a few days and returned home, again eligible for home health for a brief period until she stabilizes again. She is typical of venipuncture patients who will "ping pong" in and out of hospitals and on and off home care, at greater cost to the Medicare program, because of the exclusion of venipuncture as a qualifying home health service.

In the interview with Eli's Home Care Week and despite HCFA's indications to the contrary, the Medicare fiscal intermediary warned home health agencies against using management and evaluation as a qualifying need. "It is something that we feel agencies are going to try to use, and it is not appropriate." The official points out that observation and assessment "is generally short term, the patient comes out of the hospital following a hip fracture, for instance, and they are placed on coumadin therapy until their medical condition stabilized. At that point, the nurse needs to pull out if all they are doing is the venipuncture." Observation and assessment, the official concludes, is "not going to be the catch-all."

Restricted Availability of Part B At-Home Lab Services and Loss of Home Care Aide Services

HCFA has indicated that no one will lose venipuncture services, because Medicare covers this service by a lab technician under Part B. With regard to access to services, it is important to note that (1) currently 2.1 million people who have Medicare Part A do not have Part B and will not have coverage; (2) in many parts of the country, particularly in rural and other under-served areas, at-home lab services are not available because of long travel times, security concerns, lab technician regulations, and low reimbursement; and (3) homebound beneficiaries who access the Medicare benefit through the skilled venipuncture service will lose other home health services, including home health aide services that are critical to allowing beneficiaries to remain at home.

Out of concern for the impact of this provision on rural and other underserved areas, Senators Grassley, Rockefeller, Baucus, Bryan, and Bumpers warned in a letter to HCFA Administrator Nancy-Ann Min DeParle that, "Bedridden patients will be put at tremendous risk. Some families will be forced to somehow transport very frail seniors once a month to have their blood drawn. Many will probably go without prescribed monitoring, putting them at great risk for serious medical complications."

In a January 26 news release, the Medical Association of Alabama, like many physicians and medical groups around the country, expressed concern that with the withdrawal of the venipuncture service comes the termination of services provided by home health aides. Dr. Williamson, as the Alabama

State Health Officer, wrote to HCFA that he had "grave concerns that many home health patients, as a result of this legislative change and the interpretation of this change by the fiscal intermediaries, will be forced into emergency rooms, hospital admissions, and nursing home admissions when heretofore they have been able to be maintained at home."

No Studies, Reports, Hearings, or Assessment of Impact on Patients and Cost Shifting to Other Programs

HCFA has repeatedly stated that the venipuncture exclusion is necessary to combat fraud and abuse. However, no studies were done by the U.S. Department of Health and Human Services Office of the Inspector General nor any other agency, and no hearings were held to determine the impact that this provision would have on thousands of frail elderly or the cost shifting to other programs (such as Medicaid) that will result from it.

In announcing his support of "The Medicare Venipuncture Seniors Protection Act," Representative William Jenkins (R-TN) stated the budgetary case against the venipuncture exclusion: "If our intent is to save money in health care, it does not make sense to discontinue this (venipuncture) benefit. Many of these individuals could be placed into nursing homes and onto the Medicaid program. In Tennessee, one recent study has indicated that an additional 3,000 nursing beds will be needed by the year 2000. More beds will be needed if this inequity is not corrected." Many state governments have expressed their concern about increased Medicaid costs due to the venipuncture exclusion.

The National Council of Senior Citizens, the National Council on Aging, the National Senior Citizens Law Center, and the Older Women's League have expressed concern in a letter to Congress that the venipuncture "provision was passed without benefit of any hearings or public debate. Venipuncture should be reinstated until a number of very serious questions are answered," they concluded. "Specifically, Congress and the public should have a clear understanding of who would be affected by this prohibition."

We would like to give special recognition today to a distinguished member of this Committee, Senator Richard Shelby (R-AL) who has shown tremendous leadership in this area. Senator Shelby has introduced S. 1580, which would reinstate venipuncture as a qualifying home health service. Legislation has also been introduced by Representatives Nick Rahall (D-WV) and Robert Aderholt (R-AL) (H.R. 2912 and H.R. 3137). H.R. 2912 repeals the BBA venipuncture provision: H.R.3137 and S.1580 would delay implementation for 18 months. All three bills require a study of the venipuncture home health service and a report to Congress. We urge Members of Congress and the Senate to support these bills. As of today, the number of cosponsors on H.R. 2912 alone is approaching 100.

We urge you to delay implementation of this BBA provision until the impact of the venipuncture exclusion can be assessed as outlined in the proposed legislation. By passing such legislation, Congress could make certain that patients needing care receive the care they need while Congress works to address any valid concerns about the venipuncture benefit.

CONCLUSION

We at NAHC, along with many Members of this Committee, have pressed for the development of an episodic prospective payment system (PPS) for home health that would include an adequate case mix adjuster to account for the costs of care of intensive care patients, thus creating incentives for efficient delivery of services while ensuring that high-cost chronically ill patients are not discriminated against. We urge you to ensure timely development and implementation of such a prospective payment system, as called for in the BBA.

Medicare is a vital part of the fabric that protects our nation's most vulnerable individuals. Even it does not provide complete protection, however. Millions of elderly disabled individuals have chronic long-term care needs that go unmet. Millions struggle to pay for prescription drugs. Millions need mental health care. Rather than chopping away at home care -- a health care benefit that works and that helps keep people at home and with their families -- let's focus on the future of Medicare and look for creative ways to improve the health and lives of America's seniors and disabled population. I urge you to take action to correct these three home health provisions in the BBA that are endangering access to home health services.

Thank you again, Mr. Chairman, for the opportunity to present our views. You and the Committee have our thanks for bringing these three home health issues to this level of consideration. We look forward to working closely with you to resolve these issues, and ultimately to making PPS for home care a reality.

The CHAIRMAN. Thank you, Mr. Dombi.

Linda is my constituent, and she not only has come to this meeting to testify, but she also came to a town meeting I had. I have had this issue come up at a lot of my town meetings, as Senator Feingold already referred to, and I suppose most of my colleagues have had it brought up.

So I thank you for both then and now for coming.

STATEMENT OF LINDA FANTON, ADMINISTRATOR/OWNER, EASTERN IOWA VISITING NURSES AND HOME HEALTH CARE, MONTICELLO, IA

Ms. FANTON. Thank you, Senator Grassley.

My name is Linda Fanton. I'm a registered nurse, the owner and administrator of Eastern Iowa Visiting Nurses and Home Health Care.

Today I have come to Washington, DC, to tell the Senate of the United States about the inability of my home care agency, Eastern Iowa Visiting Nurses, as well as many, many other home care agencies, to obtain the needed surety bonds to participate in the Medicare and Medicaid program.

With me today at this hearing are two other affected home care agency owners, Julie Tow, RN, of Comfort Care, and Angie Nowak, speech therapist, of Therapy Solutions. We are all free-standing, women owned businesses in Eastern Iowa.

We are gravely concerned about the Balanced Budget Act of 1997 requirement that all home health agencies nationwide obtain a $50,000 Medicare and a separate $50,000 Medicaid bond, or a bond for 15 percent of the agency's Medicare and Medicaid revenues.

We have spent many hours calling surety bond companies, searching everywhere nationwide, for someone to bond us. Some of these surety bond companies are telling us that they won't issue bonds at all because they see them as too high of a financial risk. The ones that do issue these bonds tell us they do not approve of the way the Health Care Financing Administration has written the underwriting requirements. They all say this makes the bonds high risk financial guarantee bonds, and most require 5 to 10 times the amount in outright financial assets for each bond.

In our case, that would mean we would need $500,000 to one million in the bank to get both the bonds we need. The problem is that when the agency becomes a Medicare provider, the agency agrees to be reimbursed only for actual cost. Medicare participating agencies do not make or retain any profits, so how are we going to come up with those kinds of assets? We are not.

We will be forced out of business, no question of this fact. It is clear to us that the majority of agencies getting the bonds in our area are hospital-based agencies, which can fall back on the hospital's assets or large company chains. We know this from comparing notes with other agencies in the area. We are appealing to you, the Senate of the United States, to intervene in this matter.

I think it very important that you understand what damage has already been done here. These bond companies have had two months to form their own judgments about these bonds.

I would like to read a letter I received personally from Cincinnati Insurance Company.

Dear Linda: We previously indicated that "due to the highly hazardous bond provisions that HCFA has mandated (i.e. cumulative liability, forfeiture claim provisions, and tail-end liability) we were unable to provide bonds unless your worth was five to ten times the bond requirement."

The recent changes made by HCFA has limited the tail-end liability to 2 years if not released by another surety. The claims provisions have improved, but a demand from HCFA to pay a certain amount would be difficult to verify without substantial expense on the sureties part trying to audit. Finally, accumulative liability has not been definitely eliminated.

While the changes have been of some benefit, they do not affect the basic fact that these bonds are considered financial guarantee bonds and are underwritten on the basis of the strength of the organization and the bond exposure.

Personally, I think these bonds should be only for new home health agencies that haven't already applied for their Medicare/Medicaid certification as, Representative Thurman introduced in Florida.

Eastern Iowa Visiting Nurses is a free-standing, full service agency in Eastern Iowa that serves all age groups, and serves primarily a rural, small town area. There is only one other agency in our county, and the main difference in the service we provide is that we provide high tech nursing skills, such as intravenous therapy in the home.

We have been able to take care of patients who would otherwise be in the hospital because of the degree of nursing skills needed to care for them. Recently, we cared for a patient who requested to stay in his own home, and even though he had no home care benefits at all, the case management staff at his insurance company agreed to provide home care anyway because they knew it was much more cost effective for this patient to be in his own home rather than in the hospital. Our patients tell us that they appreciate the quality of our care, and they do appreciate a choice in their care.

Our community depends on us to provide outreach care to the sick of all ages. What will happen to the medically underserved areas in this country if we allow this to go through?

I am reminded of a February 16 letter written by Senator Grassley. "Iowans have often reminded me that they prefer to receive care in their own homes, rather than in institutions. In addition, there is little doubt that home care can be much more effective than institutional care." We owe it to the Nation's elderly, as well as people of all ages, to do this job right and correct any mistakes that may have been made.

Most of the Nation's home health agencies might not be financially worth much on paper, but our real worth is judged by the quality of care we give our patients. Sincerely, I hope that this Special Senate Committee on Aging will take swift action to avert this potential tragedy.

[The prepared statement of Ms. Fanton follows:]

SENATE HEARING TESTIMONY
RE: HOMECARE, MEDICARE AND MEDICAID SURETY BOND REGULATION

Linda Fanton, RN, Administrator/Owner of Eastern Iowa Visiting Nurses and Home Health Care, LLC.

March 31, 1998

I wish to thank the Senate Special Committee on Aging for allowing me to give my testimony at this hearing. Today, I have come to Washington, D.C. to tell the Senate of the United States about the inability of my home care agency, Eastern Iowa Visiting Nurses, as well as many other home care agencies to obtain the needed surety bonds to participate in the Medicare and Medicaid program. With me today, at this hearing are two other home care agency owners: Julie Tow, RN, of Comfort Care and Angie Nowak, Speech Therapist, of Therapy Solutions. We are all free standing, women-owned businesses in Eastern Iowa.

We are gravely concerned about the Balanced Budget Act of 1997 requirement that all home health agencies nationwide obtain a minimum $50,000 Medicare and a separate $50,000 Medicaid bond or a bond for 15% of the agency's Medicare and Medicaid revenues. We have spent many hours calling surety bond companies searching everywhere nationwide for someone to bond us. We first started with our local insurance company; when we received denial after denial we went to other larger city insurance company brokers, all with the same type of response. Finally, we went to the Internet to look nationwide and we found the same story over and over again.

Some of these surety bond companies are telling us is that they won't issue bonds at all because they see them as too high of a financial risk. The ones that do issue these bonds tell us they do not approve of the way the Health Care Financing Administration has written the underwriting requirements. They all say this makes the bonds high risk financial guarantee bonds and most require 5-10 times the amount in outright financial assets for each bond. In our case that would mean we would need $500,000 - $1,000,000 dollars in the bank to get both the bonds we need. The problem is that when an Agency becomes a Medicare provider the agency agrees to be reimbursed only for actual cost. Medicare participating agencies do not make or retain any profits. So how are we going to come up with those kinds of assets? We are not. We will be forced out of business, there is no question of this fact. It is clear to us that the only agencies getting the bonds in our area are hospital-based agencies, which can fall back on the hospitals' assets, or large company chains. We know this from comparing notes with other agencies in the area. We are appealing to you, the Senate of the United States, to intervene in this matter.

I think it is very important that you understand what damage has already been done here. These bond companies have had two months to form their own opinions about these bonds. Even now if you try to fix this they have already formed their own personal judgments regarding these bonds. I'd like to read a letter I received personally from Cincinnati Insurance Company, a major health care insurance provider and bond provider. You will notice the date

of the letter is after the Health Care Financing Administration's revisions to the underwriting requirements of the bond. The letter was dated March 11, 1998 and was written by Ronald Dunlap their Commercial Surety Manager.

Dear Linda,

We previously indicated that "Due to the highly hazardous bond provisions that the HCFA has mandated (i.e. cumulative liability, forfeiture claim provision, and tail-end liability) we were unable to provide bonds unless your worth was five to ten times the bond requirement".

The recent changes made by HCFA has limited the tail-end liability to two years if not released by another Surety. The claims provisions have improved, but a demand from HCFA to pay a certain amount would be difficult to verify without substantial expense on the Sureties part trying to audit. Finally, accumulative liability has not been definitely eliminated.

While the changes have been of some benefit, they do not effect the basic fact that these bonds are considered financial guarantee bonds, and are underwritten on the basis of the strength of the organization and the bond exposure."

Personally, I think these bonds should be only for new home health agencies that haven't already applied for their medicare/medicaid certification.

I did receive a phone call from a HCFA regional official in Kansas City. This individual told me about a possible bond agency that she said was bonding some smaller companies. They are called Centratex Support Services and are located in Brady, Texas. Well, I followed through and called them and they informed me that they are working with Connecticut Surety Group and what they do is essentially watch your agency financials; you send them a financial statement each month and then keep the Bond Companies informed of you status. As I understand it you pay two people: the company that is watching you and the bond company. My concern is that the bond company would cancel your bond the minute they found a Medicare overpayment. I would think this to be risky at best and costly especially if you need two bonds as most agencies do. What you should also know is that according to bond companies we have spoken to people are putting their homes and land up for collateral as a way to obtain these bonds.

As an experienced Registered Nurse with a home health care and hospital background, I own Eastern Iowa Visiting Nurses, a free-standing agency in Eastern Iowa that employs 3 nurses, 3 nurse aides, and 2 social workers. We contract out a full range of therapy services -- speech, physical, and occupational therapies. We serve a primarily rural\small town type of area. We see many farm families as well as small town families. The agency serves all ages of people from preemie babies to the elderly. There is one other agency in our county besides us that is a county nursing agency that has been in the area many years. The main difference in the services we provide is that we provide in-home IV therapy services and other high tech nursing services

such as ventilator management. We have been able to take care of patients who would otherwise be in the hospital because of the degree of nursing skills needed to care for them. Recently, we cared for a patient who requested to stay in his own home and even though he had no homecare benefits at all, the case management staff at his insurance company agreed to provide home care anyway because they knew it was much more cost effective for this patient to be in his own home rather than in the hospital. Most agencies do not have social workers on staff and our physicians tell us that they appreciate us having one social worker that specializes in children and one that specializes in the elderly. So if our agency closed, our county would not have access to these services. Some of our patients came from the other agency and tell us they appreciate having a choice on what home care agency they want to use and they tell us they appreciate the quality of our care.

The closest large city is 35 miles away and this is where Comfort Care and Therapy Solutions are located, in a city of with a population of 125,000. They are two of eight home health care agencies in the area. Comfort Care employs 30 people and Therapy Solutions employs 18 people. Both agencies serve all ages of people. Comfort Care reports that many of their patients have been unhappy with the care they received from other agencies and have come to their agency for that reason. Julie, the owner, reports that many of these patients have diagnoses like Multiple Sclerosis or are spinal injury patients who require a lot of labor-intensive care. They tell her they appreciate the quality of her staff. Therapy Solutions is one of the few agencies I know of state-wide that has its own therapists on staff. Angie, the owner, a speech therapist herself, reports that the physicians in the area appreciate their services because they know they can get a therapist in to see their patient within 24 hours. That is not the case in the majority of agencies who contract out their therapies because most therapy groups sell their services to several agencies. Usually it takes about two days to get a therapist out to see your patient because of sheer demand. So, you see, we fill our own specific niches in the home care market place. None of our patients want to see our agencies close because of this bond requirement; they report they are happy with our services. There also is no question that many of these people would be institutionalized without our services.

Our community depends on us to provide outreach care to the sick of all ages. What will happen to the medically underserved areas in this country if we allow this to go through?

I am reminded of a February 26th letter written by Senator Grassley, addressed to Iowa Home Health Agency Administrators: "Iowans have often reminded me that they prefer to receive care in homes, rather than in institutions. In addition, there is little doubt that home care can be much more cost effective than institutional care." We owe it to the nation's elderly, as well as people of all ages, to do this job right and correct any mistakes that may have been made.

Most of the nation's Home Health agencies might not be financially worth much on paper but our real worth is judged by the quality care we give our patients. Sincerely, I hope that this Special Senate Committee on Aging will take swift action to avert this potential tragedy.

48-320 98 - 5

EASTERN IOWA VISITING NURSES AND HOME HEALTH CARE,LLC
SURETY BOND COMPANY SURVEY

NAME OF BOND CO.	TYPE OF ASSETS ACCEPTED BOND	AMOUNT TIMES BOND AMT. NEEDED TO GET
1. THE STANDARD GROUP Three Riverway, Suite 960 Houston, Texas 77056 (713) 961-5888	Want a signed Irrevocable Letter of Credit From Your Bank in Am't of Bond	
2. CINCINNATI INSURANCE CO. PO Box 145496 Cincinnati, OH 4520-5496 (513) 870-2000	Only Business	5-10 Times the Amount of the Bond
3. AMERICAN CONTRACTORS INDEMNITY COMPANY (888) 734-7427 California	WILL TAKE HOME TRUST	Wouldn't say exactly
4. NATIONS SURETY CO. PO BOX 13323 Tallahassee, FL 32317-3323 (800) 700-6122	WILL TAKE PERSONAL ASSETS	5 Times the The amount of of the Bond
5.CENTRATEX SUPPORT SERVICES PO Box 203 Connecticut Brady, Texas 76825 (800) 588-3769	Not a Bond Co. You send them a Monthly Financial Statement- They inform Connecticut Surety	You pay them to watch you for Surety
6. CONNECTICUT SURETY GROUP	USES AN AUDIT SERVICE ABOVE	DIDN'T SAY
7. LEHR COMPANIES TIMES 3893 ADLER PLACE BETHELHEM,PA 18017	WILL TAKE PERSONAL ASSETS	5-10

The CHAIRMAN. Thank you, Linda.
Mr. Pateidl.

STATEMENT OF JAMES C. PATEIDL, THIRD VICE PRESIDENT, NATIONAL ASSOCIATION OF SURETY BOND PRODUCERS

Mr. PATEIDL. Thank you for not only pronouncing my name right, but I also thank you for the opportunity for us to come and share our concerns with respect to the regulations that have been promulgated by the Health Care Finance Administration.

My current position, in speaking today for the National Association of Surety Bond Producers, is that I am the Third Vice President. In my real job, I am executive vice president of the Lockton Companies in Kansas City, where I manage our surety operations.

First I want to make it clear that we wholeheartedly support the actions of Congress and of HCFA in trying to eliminate fraud from the Medicare system. I mentioned that we are concerned, and our concern continues even after the revisions have been made, that HCFA has proposed, that we're actually part of a recommendation made by ourselves and other members of the surety industry, primarily because of our belief that the regulations will lead to a severe and unreasonable hardship on small business in the health care profession. Accordingly, our comments today are going to be directed towards the economic study done by HCFA regarding this matter, and the impact of these regulations on the home health care distribution system as we know it today.

The surety requirement contained in the Balanced Budget Act of 1997 is certainly left open to interpretation. However, I would like to cite the sole definition of a surety bond as found in Section II, paragraph C, of the proposed HCFA regulations:

The surety bond under this rule with comment period is an instrument obtained by an HHA from a surety company in which the surety company, acting as a surety, guarantees that it will be responsible for unrecovered debts owed to us by an HHA.

After listening to the comments of the members of your committee, and other testimony this morning, I almost feel like I'm preaching to the choir, recognizing that it appears that the intent of Congress was to use the surety industry to weed out the field of home health care providers while at the same time it's obvious that HCFA has a singular focus of using the surety industry as a financial resource for recovery of funds. Note the lack of any focus on fraud in the Medicare system in HCFA's definition of a bond.

It is this fact that HCFA, through these regulations, has chosen to impose a very strict financial guarantee upon the HHA's of today and of the future that give us our cause for concern.

In the rule of comment published on January 5, there is some interesting statistics found on page 304. It states that of 9,444 HHA's, 7,958 are classified as "small entities". The criteria for that classification is based on Medicare revenue of 5 million or less. This leads me to conclude that over 84 percent of the home health agency distribution system is serviced by small business. In proportional terms, the availability of home health care for the aged and others may be severely reduced if the bonds are not available for the small independent HHA.

That brings us to the heart of our concern. It deals with the question: can small business in the home health care profession qualify for this type of credit?

Linda, in her comments, has certainly addressed her experiences, going through the surety industry, and I don't care to address what the surety industry may perceive at this point, but to deal with the facts of the home health care industry. I will defer any comments regarding the specifics of the payment system for Medicare to those who are here and have much more experience than I.

But suffice it to say that the system of cost reimbursement used by Medicare does not allow the HHA to either earn or retain a profit, as we know it as businessmen. If an HHA operates at a level of efficiency that exceeds the efficiency estimate that they have for their cost estimate, which is the basis that they receive for their interim payments, they must recognize what you and I would normally call a profit as a Medicare debt, and they must repay that debt to HCFA.

Based solely on what we now know about the health care profession and the finances of that profession, we come to the conclusion that there is more than just cause for concern as to the ability of an HHA to obtain the financial guarantee that will be required by the HCFA regulations.

Before I close, I do want to say a word about a recent set of recommendations, that either collateral in the form of U.S. Savings Bonds, or perhaps escrow accounts, would be a sufficient alternative to secure the HCFA position. I want you to ask yourself one question: if you were running a Medicare scam, would you have the money to fund this guarantee? And would you be more than willing to pay this price for a license to continue to steal?

Within the next 45 to 60 day period, after the amended regulations are published, the status of small business in health care will become a known fact. If our concerns are valid, please know that there are alternative surety products, such as the process used in Florida, that can be designed to meet the intention of Congress in assisting in the reduction of Medicare fraud.

Thank you for this opportunity.

[The prepared statement of Mr. Pateidl follows:]

Statement of the

National Association of Surety Bond Producers

to the

Special Committee on Aging
of the United States Senate

regarding

Regulations Requiring Surety Bonds
from Home Health Agencies
Participating in the Medicare and Medicaid Programs

as promulgated by the

Health Care Financing Administration
of the
U. S. Department of Health and Human Services

Submitted by
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March 31, 1998

Statement of the National Association of Surety Bond Producers (NASBP) to the United States Senate Special Committee on Aging regarding the requirement for surety bonds from home health agencies participating in the Medicare and Medicaid programs as promulgated by the Health Care Financing Administration (HCFA) of the U. S. Department of Health and Human Services

Mr. Chairman and distinguished Members of the Senate Special Committee on Aging, I would like to thank you for giving the National Association of Surety Bond Producers (NASBP) the opportunity to share our concerns on the regulations recently promulgated by the Health Care Finance Administration (HCFA) requiring surety bonds from home health agencies participating in the Medicare and Medicaid programs. I am James C. Pateidl and currently serve as third vice president of NASBP as well as executive vice president of The Lockton Companies in Kansas City, Missouri.

The National Association of Surety Bond Producers is an organization of independent agencies and brokerage firms that specialize in surety bonding for business and industry. NASBP members are responsible for producing over 70 percent of the contract surety bonds written in the United States annually and a significant portion of all other kinds of surety bonds as well.

The first five years of my surety career were spent as an underwriter for The Travelers Indemnity Company, then and now, one of the top ten writers of surety bonds in the United States. For the last 25 years, I have served as the manager of the surety operations for a private insurance and bonding broker in Kansas City. The Lockton Companies is ranked as the largest privately owned commercial insurance agency in the United States. Bonding was our foundation when the company began 30 years ago, and remains as one of our leading areas of expertise.

Without reservation, we wholeheartedly endorse the efforts of Congress and HCFA in addressing the problem of fraud in the Medicare system. However, I am concerned that the means by which HCFA proposes to use the surety industry to address this problem will lead to a severe and unreasonable hardship on small business in the home health care profession. Accordingly, I wish to direct my comments more towards the economic impact of HCFA's regulations rather than the specific contents and language of the regulations.

First, however, I would like to begin by making a brief statement regarding the nature of a surety bond, in and of itself.

Following the release of the original HCFA regulations, several health associations had informed HCFA of either the difficulty of "...obtaining the collateral to qualify for the bond", or they made suggestions such as, "... use an escrow account in lieu of a bond" and "...accept and hold U. S. Savings Bonds to secure the

collection of overpayments. Candidly, none of these suggestions have anything to do with the elimination of fraud. However, the comments are right on target when describing the nature of the bond obligation as stipulated in the HCFA regulations. Section II, Paragraph C of the HCFA regulations provides this definition of a "surety bond"

> ***The "surety bond" under this rule with comment period is an instrument obtained by an HHA from a surety company in which the surety company, acting as a surety, guarantees that it will be responsible for unrecovered debts owed to us by an HHA.***

Clearly, and by definition under the proposed regulations, the surety bond stands, in lieu of cash collateral, to secure the repayment of "overpayments" and other "debt" as defined by HCFA. Was this the intent of Congress when passing the Balanced Budget Act of 1997?

Having established the nature of the bond obligation, please recognize that a surety bond is an extension of credit, not unlike an irrevocable letter of credit which would be obtained from a bank. A surety bond cannot simply be bound or purchased like many other forms of insurance. The principal on a bond must undergo prequalification by the surety and be judged as an acceptable risk for the credit involved, before a bond will be executed.

The complaints that were made against the original bond requirements contained in the regulations were not lodged against the concept of using the surety industry to assist in the clean up of fraud in Medicare. The complaints were directed against the means by which HCFA is using the surety industry. By making the bond requirement a very strict, very large and very onerous financial guarantee, **HCFA has forced the home health care industry into a position where they must now qualify for a substantial credit undertaking.**

Can small business qualify for this type of credit? This question has to be answered before any criticisms or recommendations regarding the regulations can be understood. As I read the comments under Section VII (Regulatory Impact Analysis)of HCFA's January 5, 1998, rule, I cannot agree with some of the conclusions drawn. Without giving any consideration to the surety industry, I believe that basic reasoning supports the conclusion that these regulations will have a major impact on small business.

To fully understand our position, we have to look at some basic facts surrounding the home health care industry:

- Medicare payments are a reimbursement of approved costs.

- Efficiencies that result in lowering the cost of the delivery of home health care are returned to Medicare in the form of overpayments.

- Medicare payments are subject to a cap, establishing a maximum amount that may be received for defined home health procedures.

- Medicare payments are processed for HHA's on a weekly, and sometimes daily basis.

Consider the impact these facts, inherent to the Medicare process, have on any business operation:

- If not by design, then certainly by practice, the Medicare payment system has not allowed independent home health agencies to make and retain any meaningful level of profits.

- To offset the obvious problems of cash flow that the lack of retained capital presents to a company, the Medicare payment process allows for weekly and even daily pay requests.

The net effect of this practice has been to create an industry that has no need for professional financial reporting. Consequently, the average independent practitioner in home health care has neither the resources nor the tools allowing them the capacity to go to credit institutions, such as banks and bonding companies, to request a credit facility.

Under the HCFA interpretation of the Regulatory Flexibility Act, those HHA's generating Medicare receipts of $5,000,000 and less are considered "small entities". I would carry that one step further and call them small businesses as well. With that, I find the chart on page 304 of the regulations to be quite enlightening:

Of 9,444 HHA's, 7,958 are classified as "small entities", by this definition. That leads me to conclude that over 84% of the home health agency distribution system is serviced by "small business". In proportional terms, this has the potential of being a huge problem for the distribution of home health care services, which has a direct bearing on the welfare of the aged.

I hope that I have given you a realistic perspective of the home health care industry. It is from this perspective and foundation that I would like to now look at the nature of the HCFA surety bond obligation.

Through these regulations (even when amended as indicated by HCFA in their March 4, 1998 Notice), HCFA has established that the essence of the bond will be to provide HCFA access to a pool of funds for the primary purpose of recovering any "overpayments", as defined and ultimately discovered by representatives for HCFA.

The question here is: what does this mean to the surety?

- Under some compensation agreements between HCFA's fiscal intermediaries and HHAs, payments are based on estimates of the current year's billings which, in turn, are based on the previous year's costs taken from non-certified cost reports.

- HHA "cost reports" are not audited and/or accepted for 12 to 23 months following the fiscal year end for the HHA.

- "Overpayments" are the result of numerous reasons, other than fraud.

    ⇒ Errors made by the fiscal intermediaries in their payments and processing.

    ⇒ An efficient HHA may have costs that beat the "estimates" made in establishing the payment schedule for their fiscal year. Because the HHA was an efficient operator, they must return the excess (overpayment) to HCFA.

    ⇒ HCFA regulations for approved procedures and/or rates, are subject to changes and may be applied retroactively.

Note that none of these examples have anything to do with fraud. Note that many of the conditions impacting the status of "overpayments" have nothing to do with the quality, let alone the legitimacy, of an HHA. Note that the lag time from the point of action to the point of discovery is extremely long.

The items noted above have nothing to do with the form of the bond, or the numerous complaints about the regulations that were received by HCFA from the surety industry. These considerations deal only with the essence of the bond requirement. It becomes very apparent that the ability of anyone to accept the obligations of another, under these circumstances, is very, very risky! The credit decision to be made by members of the surety industry becomes very clear and very easy, **because they must be very conservative**.

In the RFA Impact Analysis HCFA concludes, "The majority of the HHA's will not be significantly affected by this rule" . We do not agree with that conclusion. **The use of a bond, the essence of which is a strict financial guarantee, could eliminate most small businesses from the home health care profession.**

To site another assumption in the HCFA analysis, reference is made to the influx of 450 new HHA's per year. The implication being made is that the influx of new HHA's will offset the loss of the current providers that may be the result of this bond requirement. That assumption has to be tempered by this requirement.

Regardless of the calculations to determine the funds mandated to meet the new capitalization requirements contained in HCFA's rule, if the applicant cannot obtain a bond, they will not qualify for the Medicare Provider Agreement. If it is going to be difficult for existing small businesses to qualify for this bond, consider the impact that this requirement will have on new applicants.

I do not believe that the goal of Congress in passing the surety bonding provision of the Balanced Budget Act of 1997 was to eliminate small business from the home health care profession. However, enforcement of these regulations will, at best, have a major negative impact on small business.

It should be noted that the technical changes to the HHA bonding regulations which HCFA said they intend to publish in the near future will address some of the concerns of the surety industry regarding cumulative liability and the ability of sureties to defend themselves against claims, which were very serious problems in the regulations as originally published. The notice that these changes will be made has allowed surety companies to begin the process of prequalifying and bonding HHAs, particularly larger, well capitalized firms. However, these revisions will not change the fact that the bond requirement remains a very strict financial guarantee. Nor will these changes alter the facts surrounding the nature of the home health care industry, nor, in our opinion, improve the ability of smaller, independent HHAs to obtain bonds as required under these regulations.

So, what effect will these bonding regulations have on fraud in Medicare? The answers vary.

- If sureties are allowed to accept collateral as an underwriting approach, these regulations give the fraudulent provider a license to steal.

- Management of the surety industry has an obligation to enhance and protect the investments of their shareholders. If small business is locked out of home health care, it is because the management of the surety industry has no other choice!

- There is no concurrence within the surety industry as to the information required to prequalify an HHA. Whatever information is accumulated by the surety industry will be varied in context and scattered about the industry. The efforts will be of little or no use to the authorities in fighting fraud.

- Expect the number of home health agencies to take a dramatic drop.

- Expect a drop in fraud. When you eliminate an estimated 80% of HHA's in the industry, you will certainly have some effect on the fraud in Medicare!

- Expect some improvement in the collection of overpayments. In the top 20% of the industry, HCFA should not have a problem in collection. However, within that spectrum of the industry there will be some financial failures, and there will

be some recovery from surety companies of overpayments that are not recovered today.

These results come at a fairly high price. HCFA, in collaboration with members of the surety industry, estimate the annual surety bond premium cost to be between $18,000,000 and $20,000,000. **As a non-reimbursable cost under Medicare, the premium expense becomes a tax on HHAs, levied by the Health Care Financing Administration, for the primary purpose of being able to collect "overpayments", when discovered.**

Once published, we should know within 45 to 60 days the degree to which the revised regulations result in bonds being available to small independent HHAs. Should the economic impact of the bond be deemed as unacceptable, there are alternatives in the surety industry to be explored. The remainder of this statement offers some thoughts with respects to the services of the surety industry that may be more readily available, as well as more efficient in addressing the matter of fraud in Medicare.

The surety industry can offer their **prequalification services** of home health care agencies through a **Compliance Bond** -- similar to the bond used in Florida for their Medicaid program -- if the obligation is well designed and the requirement carries reasonable penal amounts. We submit that a joint effort of the surety industry, HCFA, the home health care industry and the Justice Department could develop the underwriting criteria and applications needed to find and eliminate a substantial portion of the fraudulent operations currently impacting Medicare.

It is important to note that the underwriting associated with a Compliance Bond is substantially different than that for a strict financial guarantee as required by HCFA's regulations. The essence of Compliance Bond underwriting is to determine the qualifications of the HHA to comply with the rules and regulations governing home health care agencies, as mandated by the Medicare Provider Agreement. That would include licensing, adequate insurance, processing requirements, quality of care, as well as the payment of penalties associated with non compliance. In considering this alternative surety product, we suggest that the overall specifics of the prequalification process would be contained in a uniform application for completion by all HHA's.

We recommend that the application to be used for this bond should be designed in concert with HCFA, and then mandated by HCFA, to insure comparable steps for prequalifying all HHA's. The application form should contain a statement, to be signed by the applicant, acknowledging the fact that the information is not subject to confidentiality and that the surety is authorized to provide the information contained in the application to a representative of the Justice Department, if asked to do so. If it is possible to include such a provision in the regulations, we suggest that any falsification of the application should be classified as a felony, with incarceration as a penalty for violation.

The collateralization of these bonds should be illegal, by statute. An HHA that is guilty of fraud will be quite willing to provide collateral in exchange for a bond. The bond would legitimize their position with HCFA, and allow them to continue to extract dollars from Medicare via fraudulent schemes.

Collateral would be a small price to pay for a "license to steal". This is also precisely why any alternative, such as an escrow account or savings bonds would actually be counterproductive to the intent of the legislation contained in BBA'97.

To further this deterrent, the bond form should contain an affidavit, to be executed by the party signing the bond on behalf of the principal, which certifies that no collateral has been offered or accepted in the procurement of the bond. Falsification of that statement should be a felony offense, subject to imprisonment.

Once the prequalification of the existing HHA's has been completed, the surety industry would be left as the "gate keeper" for prequalification of the new entries into the Medicare reimbursement process.

Many members of the surety industry have made extensive studies of the home health care profession and, with their knowledge of the surety process, are certainly qualified to cooperate with the other identified parties in designing this process. In an all out push, the development of the HCFA application form and the prequalification process could be completed within 30 to 45 days. Anticipating acceptance by all parties, including HCFA, the surety industry, the home health care profession and the Justice Department, the surety industry could mount a training effort for producers and underwriters that could be completed in the "60 day comment period", following publication of the amended regulations. Within the following 60 days the HHA prequalification process could be completed.

There is a way...if we match the correct surety product to the home health care profession...and all work together.

Is this a timely assault on fraud in Medicare?

- With the "weeding out" of the fraudulent and non-qualified providers, HCFA would be left with fewer provider numbers to audit. The percentage of audits would increase, and the ability to target audits, based upon information that may be developed in the application process would improve the efficiency of that function of HCFA's fiscal intermediaries in addressing fraud.

- One would reasonably expect that the inclusion of felony charges for the falsification of the forms provided, would in itself, cause some providers to reconsider either their position or their business practices.

- The collection and management of the information by the surety industry would provide a data source for the Justice Department to improve the efficiency of

their investigations. With the recent announcement made by HCFA on March 17th, of their intention to retain independent contractors to further the anti fraud initiative, the prospects of refined data being obtained via the bond application gives even greater meaning to this recommendation.

- The large network of independent insurance agencies provides immediate and adequate access to the surety industry which would allow this process to proceed without undue hardship on the HHA's.

- The surety industry can be quickly mobilized to perform the prequalification of the HHA's.

- All at a cost of zero dollars to the federal government, since the cost of the bond is non-reimbursable under Medicare. (However, we do believe that this stipulation is blatantly unfair and tantamount to a "tax" being levied on HHAs, as we previously indicated.)

While the issue of **fraud** is the primary focus of this process, the reality of preserving the qualified and well run HHA's, owned and operated by **small business** is a secondary benefit of this approach. Conventional wisdom tells us that the industry cannot meet the demands of the elderly without the input of small business. **This is particularly true in rural America.**

A Compliance Bond of $50,000 represents an adequate penalty to be certain that the surety underwriter does their job, and does it well. At an estimated cost of $500 per provider, the expense is low enough to be absorbed by the average HHA.

We realize that the suggestion of using a Compliance Bond as a means of "weeding out" the field of Medicare providers neither addresses nor solves the problem of unpaid Medicare debt from the HHA's. However, to call upon an old saying, "An ounce of prevention is worth a pound of cure". If the existence and/or the uncollectibility of Medicare debt is a problem, then we suggest that the place to attack the problem is at the beginning of the payment cycle, and not 18 to 24 months after the fact. The fiscal intermediaries are and should be the "watch dogs" of the payment cycle. If they are not now held to a reasonable level of financial responsibility for their services, then they must be in the future.

I would like to close with the words of Representative Thurman when she introduced the surety bond provisions as part of BBA'97. The following is taken from the Congressional Record of April 24, 1997 regarding the Medicare Anti-Fraud Amendments Act of 1997 (Re: vol. 143, No. 50)

> ***We are offering this legislation to weed out unscrupulous providers in Medicare. The bill will not only protect beneficiaries and respectable providers, but also prevent the funneling of needed health care dollars into the hands of health care scam artists.***

In the case of the State of Florida, we have had tremendous success in fighting fraud in the Medicaid program by requiring the service providers such as Durable Medical Equipment Suppliers, private transportation companies, non-physician owned clinics and home health agencies, to post a $50,000 surety bond in order to participate in Medicaid. The bonding requirement is no obstacle to legitimate providers, but presents a serious roadblock to Medicaid scam artists. Through the bond requirement, Florida has reduced the number of DME providers 62%, from 4,146 to 1,565, and home health agencies have decreased by 41% from 738 to 441; these reductions have no impact on patient care.

In fact, the surety bond requirement helped Florida to identify 49 DME providers who were using post office box numbers to bilk the Medicaid program.

Clearly, Representative Thurman was focused on attacking the problem of fraudulent activity in the health care industry. With equal clarity, it is obvious that the State of Florida has derived a tremendous benefit from their surety bond requirement by eliminating an astounding number of either fraudulent or unqualified providers.

The surety product used in Florida was a Compliance Bond. There was a joint effort involving Medicaid, judicial authorities, and the surety industry. The results on the federal level even can be improved by enhancing the process.

If HCFA's bonding rule is revoked because of a misdirected objective when establishing in regulation the bond requirements called for by Congress, know that there are alternatives. This could be a unique opportunity to address the problems of fraud in Medicare, but it will call for some unprecedented cooperation between the government and private industry to establish and accomplish common goals to find and eliminate fraudulent operations.

It is certainly the desire of NASBP to see an effective implementation of the surety bond requirement mandated in BBA'97. However, we are concerned that the current regulations will have a serious impact on small business. We urge HCFA to monitor the impact of their current bond requirement and to understand there are alternatives within the surety industry that can be used to meet the intent of Congress and the needs of HCFA in controlling fraud in Medicare.

I pledge to make available the resources of NASBP to assist Congress and HCFA in this much needed effort to protect the integrity of our health system.

L:\JMHDOCS\HHATES

The CHAIRMAN. Thank you.

We've had a panel from the grassroots of America that tells us what the problem is. I thank you all very much for that.

Before I ask questions, would the person that the Administrator said would stay behind to hear this testimony identify themselves? OK. Later on identify yourself to my staff so that we'll know who to contact. Thank you very much for doing that.

Linda, once again I thank you for coming here. The Administrator emphasized the role for surety bonds in allowing HCFA to recover overpayment. I think the implication is that agencies who can't get surety bonds will be those who have chronically received large amounts of overpayments.

I want to ask you about your agency's history. Has your intermediary ever singled out your agency for receiving more overpayment than usual? Does your agency's difficulty in obtaining a bond reflect anything unusual about its history, or is the problem just because of the small size?

Ms. FANTON. Well, I guess we're reflective of a lot of the agencies nationwide in rural areas. We have significantly kept our overhead costs down, so we have never had an overpayment where we have owed Medicare any money.

I think that a lot of these people that are going to be forced out of business are scrupulously honest home health care agencies that are just trying to do their job and take care of the elderly and sick in this Nation.

I think the big problem for us is the very fact that we have kept our costs down so low, but we don't make any profits. So we just do not have the assets. You know, even with some more changes in the surety bond thing, we still could be forced out of business, because we don't make or retain any assets.

The CHAIRMAN. Thank you.

Mr. Pateidl, in your testimony you mentioned the type of review that a surety does before issuing a bond. This is something that I'm familiar with because, in the rural areas of America, grain elevators, as you probably know, have surety bonds to make sure that the farmers receive some payment at least for their grain, but more importantly, just to make sure that the person is a good, responsible business operator.

Under HCFA's proposed rules, will sureties be performing the right kind of pre-certification review for HCFA's purposes, or is there a different kind of review that sureties could perform that would be more valuable if HCFA proposed a different kind of bond?

Mr. PATEIDL. That's a pretty open-ended question, but I'll try and make it specific, if I may.

In terms of will the review to support the type of bond or the obligation that's now currently existing in the regulations do the thing that needs to be done, in terms of finding the fraudulent provider and eliminating them? It is my opinion it will not.

It has been stated that the primary reason for the bond is to allow HCFA a resource of funds to recover from overpayments or other Medicare debt. The regulations that are behind that goal are very onerous in terms of the time allowed for a surety to investigate the type of a claim, and to be able to respond and, frankly, even to defend themselves, as well as the health care agency, in the

event or when a claim is made. Consequently, what the surety has to do for the management of the surety industry to protect their own shareholders is take a very conservative approach and rely heavily on the financial condition of the health care operator.

As we stated earlier, and as Linda just pointed out, without the ability for the health agency to make and retain a profit, it's almost impossible for them to accumulate the assets to qualify for that underwriting.

Options to this, which is similar to the bond requirement in the State of Florida, deal not so much with the actual form of the bond but the form of the obligation. In Florida, the requirement of the bond is for compliance with the provider agreement for the Medicaid certification that they have in the State. That includes items like licensing and insurance, proficiencies, as well as record-keeping responsibilities that are required to assist in the evaluation and the audits as far as the Medicaid system is concerned.

There is a financial responsibility included in that bond in Florida, but the terms and conditions put on the sureties under the provider agreement are much less stringent than the terms and conditions that are under the HCFA regulations.

By going through a prequalification—and in my written testimony I have given some alternatives and would defer to that for some specifics—the surety industry represents a cadre of thousands of trained individuals on pre-qualification that is readily accessible for the home health industry to achieve the goal or be able to respond to HCFA, if the regulations were made reasonable. This is an effort that would take a concerted and perhaps even unprecedented effort between the Federal agencies of HCFA, the Justice Department, and the surety industry, to come up with some regulations that would be more palatable.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Thank you all very much, and thank you very much, Mr. Martin, for being here representing Louisiana. We've had a chance to discuss this issue on many other occasions.

Why do you think that our State is so different in terms of the reimbursement rates? I look at the most urban area in the country, maybe New Jersey, an area like that, and their reimbursement per person is probably about $2,700 in 1994. In some of the most rural areas, like our Chairman's area, the reimbursement rate in Iowa was $2,200, and Louisiana was $6,700.

In the number of visits, there is just an astronomical difference. In Iowa, the average number of visits per patient is 46, in New Jersey it was 39.7, and Louisiana was 125.

Some of us say well, we're a rural State. You look at the rural States and it's far different. And now you look at the urban States and it's far different. I'm trying to figure out what happened.

Mr. MARTIN. Senator, you're exactly right. Louisiana definitely has some problems. A lot of the overutilization in our State is attributed to an issue that's already been fixed. For years in our State we had a very low barrier to entry into the industry. There was really——

Senator BREAUX. You mean surety bond requirements?

Mr. MARTIN. For licensure from the Department of Health and Hospitals at the State level, it was very easy to get a license. There were no certificates of need that were necessary.

However, that has been fixed. The State legislature has enacted a moratorium barring any entry of new agencies into the program.

Senator BREAUX. I know that under the Medicaid program they can.

Mr. MARTIN. Medicaid and Medicare.

Senator BREAUX. Oh, for either one there is a moratorium?

Mr. MARTIN. Right. All together, through, I believe, the year 2002. That problem was partly responsible for overutilization.

I don't think we have to necessarily reinvent the wheel. HCFA already has regulations for medical necessity, and regulations for the appropriate delivery of care. I think an easy solution in our area would be to just make sure those regulations are enforced.

Senator BREAUX. As an industry, I think it's been increasing at 30 percent a year. This is a huge percentage increase in comparison to other aspects of the Medicare program. I think perhaps part of that is because it hasn't been under prospective payment. Most everything else is, doctors, hospitals, and I think nursing homes now all have moved to that. It has really brought about some curtailment of the increases in the amount of money by rewarding the more efficient operators and penalizing the less efficient operators.

But I think the interim payment system we have, Mr. Chairman, has done just the opposite than what we intended. We have locked in the inefficient operators and penalized the efficient operators. Your example is classic. You lost some employees because the operator down the road had a reimbursement rate locked in at $23,000 per patient. Yours, I take it, was more efficient, so what was yours?

Mr. MARTIN. Well, we didn't have a 1994 base year, so we are a new provider. Our utilization is, however, much lower than the State average, even lower than the regional average, but above the national average.

Senator BREAUX. So from the State's standpoint, you're locked into your lower reimbursement rate, so we're penalizing the efficient operators and rewarding those who are causing the problem.

I think we've made a mistake. How do we correct it? I mean, I don't want to throw it all out. I think we ought to get to prospective payment as quickly as we possibly can. But I hate like hell having this system that we put out there causing all these problems. We never intended to reward the ones who are inefficient, but we have done that.

How do we fix it? If we repeal the whole thing, I'm not sure that solves the problem. If we repeal the whole thing, we're still going to have these astronomical costs. But if we leave it in place, we are helping those who we shouldn't be helping, by rewarding the inefficient operators. What we should be trying to do is have this 17 billion that we spend on home health care spent more equitably, and that the efficient operators will be rewarded and encouraged to be efficient. Those who are "fly by night" operators should be penalized, and if they fly by night and are inefficient, they shouldn't be there. But we have not accomplished that, Mr. Chairman, and I'm not sure what the answer is.

But I think it's very clear—and I thank Mr. Martin and everybody here for that—that the intent of the surety bond was to say we want good operators out there, but by making them responsible for overpayments and as a collection agency for HCFA, we have scared away all the surety bond companies from doing the business. So we're touching at the problem, but I don't think we have found the answer to the problem. I think that's very, very clear.

Thank you very much.

The CHAIRMAN. I do believe that maybe our problem on the Hill would be a little more procedural and it would be substantive because of a reluctance to open up the Balanced Budget Act so soon, but that's why I'm hoping we could get HCFA to suggest some changes, and their indication of some changes might bring together enough diverse groups in the Congress to get the job done.

Senator BREAUX. That's why I commend the chairman for this hearing, because no other committee has focused on these micromanagement problems that we have in Washington except this committee, certainly on health care. It is all a part of the problem of micromanaging health care. Why do we have to do this? Then when we do do it, we don't solve the problems. We make them worse.

Thank you.

The CHAIRMAN. I don't have many more questions because we're going to have to quit here very soon because each of us have our own separate Tuesday caucuses.

Barbara, in your case you indicated that you believe the IPS is going to have negative consequences—I think you've shown that it already does, and we agree with you. But it is only scheduled, everybody would argue, to be in effect for two years. I think a lot of people would maybe take a deep breath and hope it might go away, or in a sense saying that they believe the industry will just tough it out for 2 years and get by.

I need your response to that, because you've studied it from an intellectual point of view, as well as a practical point of view.

Ms. SMITH. Yes, sir, Senator.

I don't think that waiting would be appropriate. The effect on beneficiaries, particularly very frail beneficiaries, will be very immediate. I don't think they can sustain the delays. They're a very fragile population. The effect, in terms of transfers to other health care sectors, to Medicaid and other parts of the Medicare health sectors, will also be seen fairly quickly.

The other risk is if, in fact, HCFA does run into difficulties in its implementation of the PPS system, you will be left with the interim system longer than you intend, and as you move further down the road, it's going to be harder and harder to undo the adverse consequences of it. Speaking from the perspective of caring for a vulnerable population, I think in this case we need to move promptly.

The CHAIRMAN. Mr. Dombi, if the interim payment system, as is currently structured, creates inequities for both beneficiaries and providers, do you have a suggestion on how to fix it that you would like to have us listen to?

Mr. DOMBI. Well, Senator Grassley, we have proposed several different approaches that could be taken, short of the repeal and

the moratorium. We will still end up with a lot of pain and a lot of inequity, no matter which step we take.

But I think if we look towards a rate of reimbursement which is level and equitable in a particular region, to allow one provider to serve the same population that any other provider may serve, we're a long way towards a solution. If we create some kind of an outlier system or some kind of system that might catch the higher cost patients, whether it be separate rates or a separate carve-out for that, we can disincentivize the selective admissions that are already going on with the patients as well. I know Senator Collins' office and Senator Breaux' office as well are exploring those kinds of options at this point.

Those are the two things that we think will help bring about some solution to this. But when you take 16 billion out of expenditures in the program and bring it back to 1993 levels of utilization per patient, there will be pain; there will still be victims in this scenario, and someone is going to have to pick that up. I suspect it's going to be Medicaid, it's going to be families with greater responsibilities, it's going to be the patients themselves that will suffer more than the home care providers.

The CHAIRMAN. I would also continue to note that under our Act that was passed last year, a further 15 percent reduction in home health payments will occur effectively October 1, 1999, and that is regardless of whether the full prospective payment system is in place.

Given that this reduction was set in order to achieve budget targets, what would you suggest as an alternative?

Mr. DOMBI. Well, Senator, we would be willing to work with the target to shoot for, within program expenditures, and to have a sliding reduction, and up to 15 percent if necessary to get to that budgetary savings. We believe that the savings will be achieved without having to have a further reduction in expenditures.

The CHAIRMAN. I have no further questions. Senator Breaux.

Senator BREAUX. Let me just make a comment and congratulate you again, Mr. Chairman, for focusing in on this problem. I think it really has given the industry an opportunity to be heard by the Congress. I think that is very, very important, what you have done with the committee.

I think we're in an emergency situation here. We really need emergency help for this industry. Home health care does a good job. My family has personally utilized home health care for my family. It's a very, very important service.

As we try to get a handle on the cost, we've got to make sure that we don't do more harm than we do good. I'm concerned that the interim proposals have the potential to do that. I really think it's got to be a high priority, for us to come up with something that makes sense. I think this hearing is going to lead to that.

Thank you all very much.

The CHAIRMAN. I want to thank each of you for participating, as well as the Administrator. There has been a lot of heat about these home health care issues, and we've tried to shed some light on that today. Until now, there hasn't been a lot of light shed on it.

After hearing the testimony, I am struck by the difference in the perceptions of HCFA on the one hand and the home care commu-

nity on the other. I think we've had, between these two panels, just a very wide gap. Unfortunately, we in Congress aren't in the best of positions to resolve these kinds of factual disagreements, although we will have to do it, if it's going to be done, for the most part.

I think one piece of advice that I would want to leave for HCFA is to work more closely with the home health community, and from my perspective, intensive meetings and cooperation between both sides are urgently needed. My office and my committee would be happy to be an intermediary in any of that, or even a participant in it.

As Senator Breaux has emphasized, this is something that can't wait. The time to act on these issues is very short, particularly if you consider legislative activity, because even though we're going to be in session off and on for the next 5 months, there still are not a lot of legislative days.

The surety bond final rule is expected to come out very shortly. The interim payment system's new limits are to be published any day now, and they would be applied retroactively. So we don't have the luxury of taking our time. If any legislative modifications are to be made this year, they would have to be introduced very soon.

I believe this hearing has conveyed to HCFA, and also to all of my colleagues in the Senate—and obviously, for those who are here—a real sense of urgency among home health providers about these issues. Whether we decide to act or not, these issues must be on our front burner right now.

Again, I thank everybody for helping, and I particularly appreciate the cooperation of Senator Breaux and his staff. I will now adjourn the meeting.

[Whereupon, at 12:35 p.m., the committee was adjourned.]

APPENDIX

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April 14, 1998

Testimony Submitted for

The Senate Special Committee on Aging Hearing

March 31, 1998

Testimony Submitted for the Senate Special Committee on Aging Hearing of March 31, 1998

The Surety Association of America ("SAA") and the American Insurance Association ("AIA") are appreciative of the opportunity to submit comments to this Committee on the surety bond mandate of the Balanced Budget Act of 1997 ("BBA") and the home health agency ("HHA") regulations promulgated to implement this mandate.

The SAA is a voluntary, non-profit association of companies engaged in the business of suretyship. It presently has approximately six hundred-fifty member companies, which collectively underwrite the overwhelming majority of surety bonds written in the United States. AIA is a non-profit national trade association representing over three hundred property and casualty insurance companies, most of which issue surety bonds.

The SAA and AIA commend the efforts of Congress to address the issue of fraud and abuse in the Medicare and Medicaid systems. The surety bond provisions of the BBA were intended as tools to help weed out fraudulent providers in the industry. With appropriate legislation and regulations, surety bonds can perform this function admirably, helping to maintain the integrity of the Medicare and Medicaid programs. However, surety bonds are not--and can not be--a panacea for all the systemic problems in such large and complex programs.

The HHA final January 5, 1998 regulations, promulgated by the Health Care Financing Administration ("HCFA"), generated a number of problems for HHAs attempting to obtain the mandated Medicare and Medicaid surety bonds, each in the minimum amount of $50,000. As published, the regulations inhibited the development of a thriving and viable surety market. Sureties were concerned about a number of issues. Some of these concerns have been addressed by HCFA in its February 27, 1998 Notice of Intention To Amend Regulations. The Notice stated that these amended HHA regulations will require a claims-made bond, create a two-year extended discovery period, and protect the appellate rights of sureties, addressing three major surety concerns. These regulations are expected to be published any day.

One point repeatedly emphasized at the March 31 hearing is that, when Congress mandated a surety bond for HHAs and other providers in the BBA of 1997, it intended the bond to ferret out fraudulent activity, not provide a safety net for the system's own internal payment glitches in the form of overpayments. We urged this same point to the HCFA regulators in our meetings and conversations with them last fall.

In enacting the surety bond provisions of the BBA of 1997, Congress inadvertently placed a disparate burden on small HHAs. This mandated $50,000 bond minimum for Medicare and Medicaid surety bonds creates, in effect, a $100,000 bond

minimum for HHAs that wish to participate in both programs.

We offer two remedies for this situation: one, legislative and the other, regulatory. The SAA and AIA would support a proposal that the current law be amended to reduce or eliminate any minimum and make all bonds a set percentage of prior year revenues. In addition, we have suggested to HCFA that it consider a dual obligee rider to eliminate some bonding problems for small providers. The effect of a dual obligee bond would be one $50,000 bond for both the Medicare and Medicaid programs. In fact, during her testimony at the hearing, the HCFA Administrator, Nancy-Ann Min deParle, noted that HCFA is reviewing the possibility of requiring one bond for providers of both Medicare and Medicaid services.

Since even before the enactment of the BBA of 1997, the surety industry and the HHA industry have been engaged in learning about each other's businesses. These complex businesses have in common a steep learning curve. The surety industry is not easily understood and misinformation is a common problem. One of the principal missions of both the SAA and AIA is to educate the public and public officials about the benefits of surety bonds. With this comment as background, we would like to respond to some of the remarks at the hearing.

One witness, representing the National Association of Surety Bond Producers ("NASBP"), proposed as an alternative to the current rule a "Compliance Bond, not

unlike the instrument used in Florida for their Medicaid initiative." Compliance is a very broad term, and a compliance bond has meaning only in the context of the underlying obligation--whether rules, regulations, or statutes. Typically, compliance bonds are low-risk obligations running to a state or municipality, guaranteeing the principal (i.e., the person or entity for whom the bond is issued) will comply with statutes or ordinances. Examples include license bonds for electricians, general contractors, and plumbers, with a typical penal sum of $5,000 to $25,000.

Adopting the Florida Medicaid model is unlikely to provide the kind of relief proposed by NASBP because the Florida bond requires compliance with the Florida Medicaid Provider Agreement, which expressly includes repayment of overpayments as a duty of the provider. Ms. Min deParle stated, in response to questioning, that the bond under the Florida Medicaid provider agreement permits the Medicaid agency to recover overpayments, whether or not the agency has chosen to seek such recovery under the bond.

In fact, a bond designed to ensure compliance with existing Medicare and Medicaid rules and regulations could be interpreted to provide even broader coverage that the existing requirement for a bond to repay overpayments since the duty of an HHA to repay overpayments is merely one of the requirements in several volumes of Medicare and Medicaid regulations.

Rather, if Congress wishes to use the surety bond instrument as a tool to combat fraud and abuse, it could enact a statute specifically requiring a fraud bond. Unlike the current bond proposed by HCFA, this bond would not cover repayment of overpayments, but repayment of losses caused by fraudulent activities of HHAs.

The NASBP witness further suggested that "[t]he collateralization of these bonds should be illegal." We disagree with this proposal. It is a standard practice for a surety to require the principal to provide collateral to supplement the financial resources of the bond principal itself. NASBP stated that "the bond form should contain an affidavit, to be executed by the principal, which certifies that no collateral has been provided the surety as a condition of its issuing the bond." To falsify such a statement, argued NASBP, should be a felony offense.

Collateralization is one tool used by the surety industry to strengthen the position of an entity attempting to obtain a bond. To eliminate one of these tools, which could benefit in particular smaller HHAs, seems poor policy.

One witness implied that small HHAs in general are having difficulty obtaining surety bonds. It is our understanding, corroborated by Ms. Min deParle's testimony, that a significant number of small HHAs already have obtained the requisite surety bonds. We believe that once the amended regulations are published an even more viable market will be created.

We continue to be ready to assist both Congress and HCFA in seeking solutions to foster a robust environment for Medicare and Medicaid surety bonds.

Statement of
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Submitted to the
Senate Special Committee on Aging

United States Senate

ACCESS TO CARE: THE IMPACT OF THE BALANCED BUDGET ACT ON MEDICARE HOME HEALTH SERVICES

Tuesday, March 31, 1998

Mr. Chairman and members of the committee, on behalf of Home Care Association of America (HCAA), I am honored to share our views concerning the critical issues related to the New Medicare Provisons Affecting Home Health Care. HCAA represents over 450 freestanding home health agencies across the United States.

This submittal is divided into four sections:

I - The Home Health Surety Bond

II- The Interim Payment System (IPS)

III- Venipuncture

IV- Hospital Self-Referrals

I hereby request that if this committee considers holding additional hearings pertaining to home health care, that I be invited to offer verbal testimony before the committee on behalf of freestanding agencies which represent 49 percent of the industry. I would also request that representatives of the National Association for Home Care, the American Federation of Home Health Agencies, the Home Health Staffing and Services Association, and the two largest state associations, California Association for Health Services at Home and the

Texas Association for Home Care also be invited to provide verbal testimony to this committee on the key issues of the Balanced Budget Act of 1997 that affect homebound patients across the nation. All of these organizations are strongly united on the critical issues of Surety Bonds, the IPS and Venipuncture

Section I- The Home Health Surety Bond

In the January 5, 1998 Federal Register, HCFA issued a **Final Rule** pertaining to the Surety Bond for home health care agencies (with comment period ending after the deadline for purchasing a Surety Bond). **HCFA's rules will force many honorable home health agencies out of business and HCFA has clearly overstepped the intent of Congress** (found in Section 4312 of the Balanced Budget Act) with these regulations. **Since release of the Surety Bond regulations, 99% of all surety companies on the Treasury's approved list have refused to write the bond.** The remaining 1% of these companies are fearful of approving this bond in its current form. Most companies have refused to issue these bonds because of HCFA's extreme regulation (cumulative liability limits, open-ended obligation, and broad attachment conditions).

In the January 23, 1998 issue of USA Today newspaper, reporter Peter Eisler reported, ***"Surety officials say only a fraction of the 10,000 or so home care providers needing a bond will get one."*** **Another quote from the report states,** ***"The only (home care providers) who would be able to get these bonds would be the very biggest, says Martin Huber of the National Association of Surety Bond Producers. As the rules are written, 'the surety doesn't know the limits of its liability. It's too risky.' Among bonders' concerns: Capitalization: To reduce risk, many bond writers want home care agencies to put up unusually high collateral. Small and medium sized agencies generally don't have the assets, nor do nonprofits. Process: The government can make claims on a home care agency's bond without going to court. Bond writers don't like the lack of appeal avenues."***

The OIG and HCFA have given very misleading reports and have therefore, created pressure on Congress to drive so-called "fraudulent" home health agencies out of business. It seems clear that HCFA is a government bureaucracy that lives on expanding its power and driving honorable home health agencies out of business, while the OIG has "apologized" to home health agencies who were wrongly placed on a list of "problem agencies". None-the-less, the OIG is continuing in standing by the results of this misleading report to Congress. HCFA (and its fiscal intermediaries) are identical to the Internal Revenue Service in attempting to collect as much money as possible (wrongly or rightly) so that they can report to Congress and the media the benefits of their actions. HCAA shares Congress' concern about true fraud and abuse, however, by making the regulations so extreme that only very large publicly-held chain agencies, including hospitals-owned agencies are the only agencies wealthy enough to purchase a bond, Congress is inadvertently creating a home health monopoly and rewarding those type of

companies who have been the main perpetrators of fraud. Freedom of choice of provider and competition will be nonexistent. **Also, do not be fooled that Provider Service Organizations and "Medicare-Choice" plans will fill in the gap.**

The government will have to spend millions of dollars (as it has done to attract Medicare beneficiaries to HMOs that have ended up costing the government far more money than traditional fee-for-service Medicare) to persuade beneficiaries to join these untried and risky health care plans.

This extreme Surety Bond **final** regulation is proof that HCFA's hidden agenda is to drive primarily honorable freestanding home health agencies (who cost far less to provide care than hospital-owned home health agencies) out of business by issuing regulations that cannot be complied with. Under the guise of Operation Restore Trust, (ORT - more details about ORT can be found in this testimony) and the Wedge Survey, HCFA is again showing that it seems to be their intent to force primarily freestanding agencies (many who have been in business for many years) out of business without due process.

The following paragraph comes from a letter dated January 19, 1998 by Leigh Anne Cedeno, AAI, CIC, Director of Royal Benefits Planning of Jacksonville, Florida to the Health Care Financing Administration in response to commenting on the final Surety Bond regulation. I believe this paragraph will give the committee insight pertaining to HCFA and the Surety Bond Regulation:

"Before HCFA issued the final Surety Bond regulation, I telephoned Mr. Ralph Goldberg at HCFA and he advised that HCFA utilized the expertise of the National Association of Surety Bond 'Producers' (NASBP) when drafting the bond specifications. Unfortunately, since talking with Mr. Goldberg my research has shown that NASBP is an association mostly comprised of commission earning insurance agents, not surety underwriters. NASBP president Mr. Darrell C. Dodson, wrote that this bond 'is great news for our industry' because I believe NASBP members saw big dollars signs if they could get the bond issued. It appears HCFA did not contact the surety companies that would be at risk for these bonds. If HCFA had contacted the surety companies opposed to NASBP (the people who would profit from this mandate), HCFA would have known that this bond (under HCFA's <u>current</u> specifications) is uninsurable."

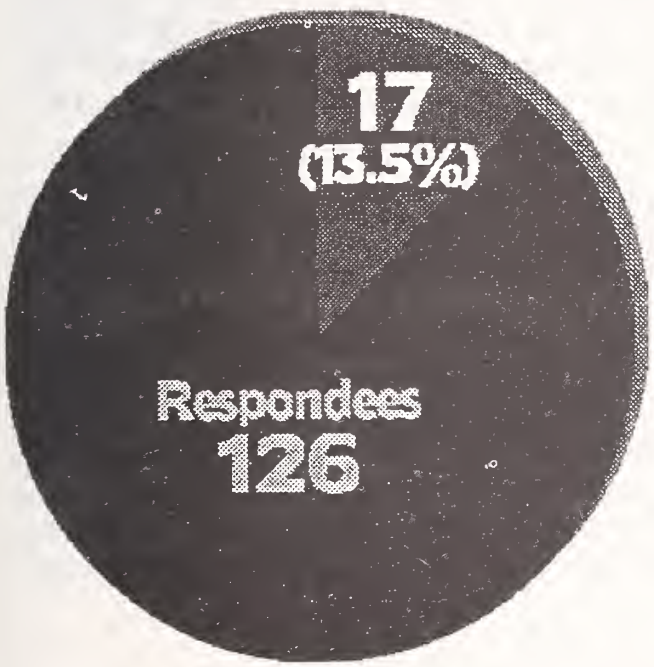
HCAA is also concerned that HCFA has chosen to establish a "flat rate to determine the amount of the bond that will be used in combination with a $50,000 minimum bond." We are concerned that 15% of HHAs Medicare payments is far too large of a percentage to base the amount of the bond on. The January 5, 1998 Federal Register states, "In 1993, Medicare overpayments were 4 percent of total Medicare payments made to all HHAs. In 1996, Medicare overpayments had grown to 7 percent of total Medicare payments made to HHAs." **Why then would HCFA overstep the intent of Congress by including a 15% penalty in the final Surety Bond regulation?**

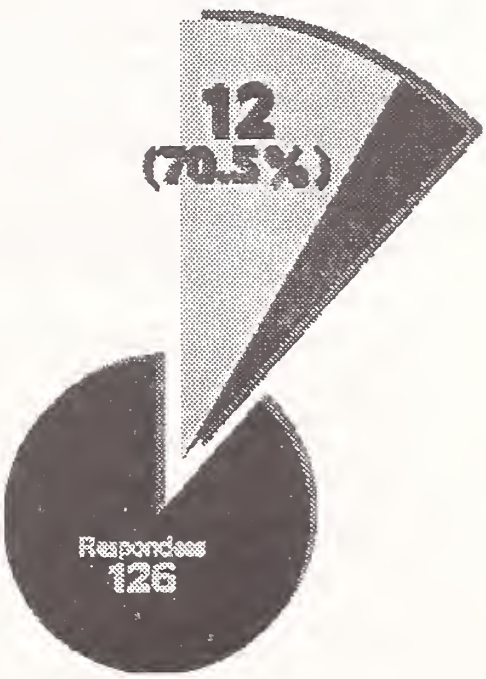
If HCFA insists (and Congress does not stop HCFA) on using the Surety Bond as a means of recouping Medicare overpayments, then the bond requirement of $50,000 or 15% of revenue should be adjusted to $50,000 or 2% of revenue because in 1996, the percentage of uncollected Medicare revenue was only 1.070%. It should be noted that Chairman Grassley and other members of the Senate have written to Administrator Min-Deparle stating that it was not the intent of Congress to use the Surety Bond as a means of recouping Medicare overpayments.

On March 4, 1998, HCFA released via the Federal Register (Volume 63, Number 42) a "Notice of Intent to Amend Regulations". The summary of this notice states, " This document announces our present intent to make technical revisions tothe surety bond and capitalization regulations for home health agencies (HHAs) published on January 5, 1998 (63 FR 292-355). These intended revisions include: generally limiting the Surety's liability on the bond to the term when it is determined that funds owed to Medicare and Medicaid have become "unpaid," regardless of when the payment, overpayment or other action causing such funds to be owed took place...)

Several letters from members of Congress, including Representative Karen Thurman (D-FL), Chairman Grassley, and Senator Bond express concern over HCFA's interpretation of the law.

To prove the point that most freestanding agencies would not be able to obtain the required surety bond, HCAA conducted a survey of Medicare agencies in the state of Texas. The results of our survey clearly illustrated what we believed. Of those agencies responding to our survey, (126) only 17 or 13.5% had been able to obtained bonds. And of those that had obtained bonds, 12 or 70.5% had bonds with a face value of $50,000. (See charts below) Just one agency received a bond for over $100,000. Simply put, this means that agencies providing over 500 visits a month, are not able to obtain bonds.





In a similar survey conducted by American Federation of Home Health Agencies, Inc. (AFHHA), the results show:

Hospital-Based Agencies Responding	Number of Agencies UNABLE to get bond	Percentage that are women/ minority owned
17	1	N/A

Freestanding Agency (Non-Profit) Responding	Number of Agencies Unable to get bond	Percentage that are women/ minority owned
25	21	91%

Freestanding Agency (For Profit) Responding	Number of Agencies Unable to get bond	Percentage that are women/minority owned
109	100	88%

HCAA requests that HCFA makes the following changes to the regulation:

1) HCFA should take into account that fiscal intermediaries already "withhold" payments to HHAs using the **audit adjustment factor**. The 15% requirement (which was not included in the law) arbitrarily imposed by HCFA should be stricken from the regulation.

2) The limit of liability should be for one year only, not cumulative and not infinite.

3) The conditions for accessing the bond should be for fraud and bankruptcy only.

4) The rule should not be retroactive (to January 1, 1998 or to any date before the rule is finalized). HCFA officials have informed HCAA staff that the regulation stands as is (unless directed otherwise by senior HCFA officials), and that home health agencies that continue to provide care will not be reimbursed for services rendered from January 1, 1998 if they are unable to purchase a bond.

5. HCFA must allow honorable freestanding agencies which have been in existence over 2 years to be exempt from purchasing a surety bond.

Section II- The Interim Payment System for Home Care

HCAA is very concerned that the Interim Payment System (IPS) for home health care (Section 4602 of the Balanced Budget Act) will force many patients who are under a physicians plan of treatment of home care into more expensive nursing homes and hospitals. Already across the United States, due to the projected "per-beneficiary cap", home health agencies (who are under the IPS caps) are being "forced" (due to unreasonable IPS per-beneficiary caps) into discharging patients who desperately require home care services. The reality of the matter is that if the "national" cap is four thousand dollars per patient (in the aggregate), home health agencies cannot treat patients who require more intensive care.

The life-threatening flaws of the IPS include:

1) IPS improperly returns home health care cost and care levels to fiscal 1994 (in many cases, 1993 levels due to the home health agency's fiscal year end). This FY 94 level is not adequate considering that hospitals were not discharging patients as quickly and in such a deteriorated condition as they are in 1998 and considering that wages (which represent over 70% of home care costs) were significantly lower in 1994 (as they were for all American employees).

2) The IPS creates "unfair competition" and improperly pits home health agencies against each other to treat patients. Some agencies are under IPS's inappropriate caps while others are not - clearly an improper and unfair regulation. In my own hometown of Jacksonville Florida, our agency with a cost-report fiscal year of December 31 has already taken steps to comply with our "lower" IPS payments, while other agencies which have a cost-report fiscal year end of June 30 are not affected by the Interim Payment System and they are offering our employees and our patients increased salaries and home care services. This is causing confusion among home health beneficiaries because agencies not currently affected by IPS are informing patients that they can receive "More Care" from them versus an agency currently under IPS.

3) The current IPS plan requires an agency to use the "unduplicated census count of patients". Unfortunately, many agencies may have inaccurate data due to "flu-shots" being given to the public. The problem is that there is no "case-mix adjustment" to properly reflect "changing" patient care needs and/or "changing" patient care populations.

4) Lastly, HCFA's is currently unable to "prorate" the per-beneficiary limitations between home health agencies treating the same patient in the same year. HCAA believes (and at least one of Medicare's intermediaries have confirmed) that HCFA will be unable to determine (a pro-rated beneficiary cap) in a reasonable timeframe, for patients receiving home care from more than one home health agency. This will mirror the problem currently in the HMO industry where a patient signs up for an HMO without telling the home health agency currently treating the patient, with the impression that the patient is in the

traditional fee-for-service Medicare program. The home health agency continues providing services, only to learn that neither Medicare, nor the HMO will reimburse the home health agency for services rendered while the patient was enrolled in the Medicare HMO.

HCAA recommends the following solutions to the Interim Payment System:

1) Change the "base year" of the per-beneficiary cap to 1996 cost data, versus 1993, to more adequately reflect adequate and necessary care and cost levels.

2) Ensure that a "regional" average is used versus a "national" average. Care levels are different in different areas of the country, i.e. more managed care is found in California while in Louisiana and Texas, fewer Medicare beneficiaries are choosing managed care plans.

3) Implement IPS "uniformly" to "all" agencies at the same time - i.e. "all" agencies should be subject to the "per-beneficiary caps" on the same date, not based on their fiscal year end.

4) A "case-mix adjuster" in the "per-beneficiary caps" should be made to account for low visit volume patients in the base year.

5) Ensure that home health agencies that have been in business for over 3 years and changed the status of their company from a C corporation to an S corporation are able to use the "regional cap" instead of the "national cap".

6) Recommend that Congress pass H.R. 3205 by Representative McGovern and S.1643 by Senator McGovern before the end of this Congress. HCFA must be instructed to postpone implementation of the Interim Payment System. HCFA has been charged to develop a prospective payment system for home health care by October 1, 1999. HCFA is already overwhelmed by Congressional mandates, so HCAA believes that HCFA should concentrate on developing the Prospective Payment System for home health (which is due October 1, 1999)

Section III - VENIPUNCTURE

Section 4615 of the Balanced Budget Act mandates that No Home Health Benefits Based Solely on Drawing Blood (will be reimbursed by Medicare).

There has been much confusion on this issue. It is true that if a patient "qualifies" for another skilled nursing service under the home health benefit, then venipuncture will be covered. It is unfortunate that HCFA is forcing home health agencies to find, "another rung to hang their hat on" for a homebound, doctor-certified Medicare patient to receive a blood draw from a home health care nurse. This will certainly cost more money (having additional SKILLED nursing services) versus just reimbursing for venipuncture (and possibly correct home health aide visits).

In a March 10, 1998 letter from HCFA Administrator Min DeParle to Members of Congress, Ms. Min DeParle states, "For those beneficiaries who no longer qualify for home health, their blood draws will be paid under Medicare Part B. If a beneficiary is unable to travel to a clinic or physician office, then laboratories may travel to the beneficiary's residence to draw blood."

What Ms. Min DeParle did not state is that over 2 million, (2,000,000) elderly Americans do NOT have Part B coverage. In addition, several HCAA members have reported that the reimbursement for a lab to do a blood draw is only $13, and even with reimbursement of mileage expenses, labs will choose not to provide this critical service.

HCAA calls on Congress to enact H.R. 3137 (Introduced by Rep. McGovern) and S. 1850 (Introduced by Senator Kennedy) to reinstate venipuncture as a covered service (on its own merit) while conducting a one year study to research any possible fraudulent activity pertaining to this service.

Section IV- Hospital Self-Referrals

Eventhough this hearing does not cover hospital self-referrals, I feel it is imperative that this committee know the truth about why home health care costs have skyrocketed over the past several years.

In the July 17, 1997 issue of the Fort Myers News-Press, reporter Mike Hoyem states,

"Home health care visits in Florida cost Medicare more than $1.3 billion per year. Statistics show home health care in Florida is more expensive for federal taxpayers when it's done by hospital-based home health care agencies:

Last year there were 64 agencies whose average bills for a home health care visit were $80 or more. Forty-four of them were hospital-based, and 20 were independent.

140 agencies charged $70 or more: 93 were hospital-based, and 47 were independent.

Sixty-nine agencies had bills averaging under $60; 19 were hospital-based, and 50 were independent.

Thirty-two agencies had average bills under $50; 25 were independent, and seven were hospital-based."

Referrals of home health patients from the hospital to there hospital-owned home health agencies is a serious matter because hospital home health care costs Americans more money than freestanding home health care. The hospital makes more money when patients are referred (or steered) into the hospital-owned agency. In some cases, hospitals immediately steer patients into there own home care agency UPON ADMISSION into the hospital.

One of the most critical issues to freestanding, entrepreneurial home health care agency owners is the issue of hospital self-referrals. The key words that we have heard over the last three years of the Republican-controlled Congress are "competition" and the "free-market." If this committee and this Congress truly believes in these principles, then we ask that freestanding home health agencies be allowed to compete on a level playing field with hospital-owned/based agencies. In addition, this committee should review the December 9, 1997 OIG report entitled, "Medicare Hospital Discharge Planning" (OEI-02-94-00320). This report confirms what HCAA has been telling Congress for over 3 years. Two quotes from this report states, "***Hospital ownership does seem to have influence on which home health agencies patients are referred to"and "Hospital ownership also influences the duration of home health agency services." (Emphasis added).***

Currently, 42 CFR 424.22 entitled, "Requirements for home health services" states:

(d) Limitations on the performance of certification and plan of treatment functions.- (1) Basic rule. Beginning November 26, 1982, and except as provided in paragraph (e) of this section, need for home health services to be provided by an HHA may not be certified or recertified, and a plan of treatment may not be established and reviewed by any physician who has a significant ownership interest in, or a significant financial or contractual relationship with, that HHA.

Section (e) states: Exception to limitations- (1)Exceptions for governmental entities. The limitations of paragraph (d) of this section do not apply to an HHA that is operated by a Federal, State, or local governmental authority.

In addition, 42 CFR 424.22 section (3) clearly states:

Significant financial or contractual relationship. Beginning November 26, 1982, a physician is considered to have a significant financial or contractual relationship with an HHA if he or she-

(i) Receives any compensation as an officer or director of the HHA; or

(ii) has direct or indirect business transactions with the HHA that, in any fiscal year, amount to more that $25,000 or 5 percent of the agency's total operating expenses, whichever is less. Business transactions means contracts, agreements, purchase orders, or leases to obtain services, supplies, equipment, and space and, after August 29, 1986, salaried employment.

History

HCAA has always believed that this regulation is crystal clear. Hospitals are prohibited from having doctors certify or recertify plans of treatment to hospital based/owned agencies if the doctor is employed by the hospital, and that doctor receives compensation over $25,000. Opponents of this regulation say that new health care systems developed over the past several years have made this regulation outdated and obsolete. The American Hospital Association (AHA) has lobbied hard to have Secretary Shalala declare a "moratorium" on enforcing this regulation until Stark II legislation is finalized. **HCAA believes that improper hospital self-referrals drive up costs, eliminate competition and denies patient choice.**

I recently read a quote from Representative Thomas Bliley of Virginia pertaining to competition. Representative Bliley stated, **"Last Congress, we broke up one of the biggest monopolies still standing, giving consumers a choice in local telephone service. It's time we did the same thing with electricity." Also he said, "no economist can quarrel with" the notion that "competition lowers prices, competition improves productivity, and monopolies are always inefficient and expensive -- always. That's not opinion, it's fact. You know it, I know it, ... and history proves it."**

Representative Bliley is correct in his comments. **Competition is the key to lower prices, higher quality and patient satisfaction.** When telephone companies, airlines, cable television operators and fast food restaurants are allowed to compete fairly, prices go down and quality goes up. However, that doesn't mean that safeguards are done away with. It is imperative that regulations remain in place to ensure companies do not sacrifice quality in favor of profit. Federal agencies, like the FDA are necessary to ensure that food is safe to

eat. In the same way, the Department of Justice, OIG and FTC should ensure that, in the health care sector of our economy, patients have the freedom to choose their own health care provider, especially home health care.

Consider that the hospital has a "captive patient." The patient has received services while in the hospital and then when the patient is discharged to home health care, it is logical that the hospital would want to have that patient remain in the hospital system. The excuse a hospital may use is, **"we want to ensure that you are given continuity of care."** Eventhough freestanding, Medicare-certified home health agencies are in the community, the hospital may be reluctant to lose the Medicare dollars associated with that patient. Then, if the patient returns to the hospital, the hospital may be able to receive that patient under a new DRG and again drive up health care costs.

The main issue you should consider is **PATIENT CHOICE**. In many instances throughout the country, we have heard from freestanding home health agency owners that patients they have been treating, when readmitted into the hospital, are in some cases discharged to the **HOSPITAL-OWNED/BASED HOME HEALTH AGENCY.** Hospitals must honor patient choice and put aside profit. It is imperative that the patient is allowed, without coercion or manipulation, **the freedom to choose his post-acute provider, and the choice must be honored by the hospital.**

The freedom to compete for providing health care services is also a concern. HMOs and hospitals have the financial resources to place **FULL PAGE ADS** in newspapers and have **LARGE ADVERTISING BILLBOARDS** to lure patients into their care. Freestanding home health agencies do not have the resources to compete with this type of advertising. Certainly, Medicare provides reimbursement for limited types of education, but HCFA is reluctant to pay for any advertising except in the case of recruitment.

We urge the committee to ask HCFA to maintain and vigorously enforce the "Hoyer Commentary" pertaining to 42 CFR 424.22 and ensure that hospitals allow freedom of choice to patients.

SUPPLEMENTAL SHEET

I am hereby including this supplemental sheet with the written testimony of Mr. Dwight Cenac, Chairman of the Board of Home Care Association of America (HCAA).

Name of Witness: Mr. Dwight Cenac, Chairman of the Board, Home Care Association of America (HCAA).

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Topical Outline:

This submittal is divided into four sections:

I - The Home Health Surety Bond

II- The Interim Payment System

III- Operation Restore Trust

IV- Hospital Self-Referrals

Perspectives on Medicare

Prepared by the
Utah Association of Home Health Agencies (UAHHA)
March 1998

Introduction: Balanced Budget Act of 1997

The Balanced Budget Act of 1997 (BBA) embodied a valiant and essential effort to control the burgeoning federal deficit. It also exacted a toll — and will continue to do so for some time — in terms of free enterprise, cost-effective medical and personal care, patient's choice, and quality of life. This prompts the home health industry's action.

The industry's similarly valiant undertaking has one overriding objective; to foster and promote high standards of patient care. Medicare-certified agencies operate in a cost-based arena, therefore, profit may be discounted as a motive for their vigilance. However, other economic and quality assurance factors must be examined.

Should an agency cease operations because of restricted Medicare funding or other federal constraints, a negative fiscal impact is realized by the company's owner, by its employees, and by the communities in which it conducts business. Patient and provider rights are jeopardized. In rural and/or under-served areas, monopolies may emerge. (Service may not be available from any provider!) Fraud and abuse, which has been checked in large part by the industry's recent zero tolerance position, could resurface.

While the BBA is essential for the economic health of our nation, its inherent negative points could cause the demise of hundreds of job-creating, tax-paying companies and the recipients of medically-necessary home care.

Particularly onerous portions of the BBA include (1) eliminating venipuncture as a Medicare qualifying service; (2) establishing cost limits and per-beneficiary limits as part of the Interim Payment System (IPS); (3) setting unrealistic surety bond requirements; and (4) restricting patient referrals and adequate care plans. These have combined to dramatically impact Utah's home health industry. Agencies have experienced a 30-35 percent decrease in Medicare business since January 1, 1998. It is projected that, by year's end, they will provide only 50 percent of the service volume rendered in 1997. That may have been the intent of Congress, the Administration and the Health Care Financing Administration (HCFA), but it is too radical. Beneficiaries will suffer!

Each of the aforementioned problem areas within the BBA will be discussed and, in some instances illustrated, on the following pages.

Venipuncture

Recent changes in Medicare benefits — with their accompanying cost shifts — caught the State of Utah and local governments unprepared to provide medical and personal care to many homebound individuals. An informal survey of UAHHA provider members showed at least 2,000 elderly Utahns were impacted when the Medicare venipuncture (blood draw) benefit was eliminated as a qualifying skilled service.

As previously allowed under Medicare rules, these venipuncture patients accessed personal (home health aide) services with physicians' orders. In lieu of moving to a skilled nursing facility, aide services allowed them to maintain their dignity, receive appropriate care, and stay in their homes where they were more comfortable.

Because aide services could be procured via federal resources, state and local programs have not been sufficiently developed nor funded in the Beehive State. Yet legions of elderly, in time, will require skilled nursing care because of the venipuncture prohibition.

The Association's best guess is that 300 of these former venipuncture patients live in congregate housing or with family members. They will probably maintain needed services from their cohabitants. Another 700 will pay for necessary services privately or be served by family members, neighbors, church members, or others outside their own households. They, too, will likely be able to maintain their quality of life. However, the medical conditions of 1,000 people will deteriorate. They will need nursing facility services or hospitalization. Some will die if they receive no intervention.

But local aging agencies, which could provide these required personal care services, are already financially strapped. Today 900-plus Utahns are on waiting lists to receive services. By the end of the year, those lists could double with the influx of former venipuncture patients.

Several questions beg answers:

- Can state and local revenues keep pace with the demand for aging, social services, and health programs? Earlier this year, lobbying by UAHHA and aging agencies personnel resulted in state legislative approval of "building block" monies to address the problem. But the appropriation was less than one-fourth of what is really needed.

- Will these patients require hospitalization or nursing facility care before personal care is available? If their medical conditions deteriorate and admission to a skilled nursing facility is warranted, the annual cost to taxpayers could exceed $25,000 per patient each year. That compares to $6,211 for Medicare-provided home health services, $2,136 for alternative services, and $1,553 for locally provided homemaker or personal care services. An average, two-day stay in a hospital costs roughly the same as a full year of home health care!

- Will these patients live long enough to secure personal care?

The following scenarios, submitted and documented by Utah home health agencies, may help answer that last question. These cases are typical of those reported each week:

Seven clients who were discharged by Horizon Home Health, Salt Lake City, prior to the effective date of the venipuncture prohibition (February 5, 1998) have been readmitted. The worst case involves a woman the agency had monitored for Protime and blood thinning regulation and evaluation. At the point of discharge, her lab values had been stable. Caregivers could not keep her qualified for Medicare benefits with any other skilled service. Some time after discharge, she went to the emergency room at a local hospital with some minor bleeding. She was admitted and remained hospitalized for 10 days. During her stay, she received lab work and a simple ultrasound — all services that could have been provided at her home.

Applegate Home Health, American Fork, discharged a patient for the same, venipuncture-related reasons. Her blood draw benefit had permitted home health aide visits three times per week to assist with homemaking duties. The first morning after being discharged, she and her husband attempted to make their bed — a service formerly performed by the aide. She fell and broke a hip which necessitated an extended hospitalization.

Premier Home Health, Salt Lake City, reported on one patient who received service until February 4, 1998 when the venipuncture provision became effective. Besides monitoring her Dilantin level, this patient's blood draw service enabled her to receive help with her bathing, dressing and other activities of daily living. After discharge, however, she fell and cut her forehead. The wound required a visit to the emergency room and stitches. A week later, on March 22, 1998, she was hospitalized after experiencing grand mal seizures. Physicians put her on full life support and she is currently in intensive care. Premier staffers, had they been able to make regular, Medicare-qualifying visits to the home, may have been able to observe the precursors to this final event (headaches, dizziness, numbness, and fall) and alleviated the need for medical intervention. At this time, the patient's prognosis is "uncertain."

While it is still too early to assemble statistically valid data on the negative effects of the BBA, insiders cite developing trends with concern.

The Utah Bureau of Medicare/Medicaid Certification and Resident Assessment reports the total census for nursing and skilled nursing facilities is down from 1997 figures. But government-provided care is increasing. The agency provided the following statistics:

Summary Information	Jan. '97	Feb. '97	Jan. '98	Feb. '98	Change (Feb. '97 to Feb. '98)
Total Certified Beds	7,539	7,539	7,581	7,502	- 0.5%
Total Private Pay Census	1,649	1,683	1,707	1,703	+ 1.2%
Total VA Contract Census	44	50	43	38	- 24.0%
Total Part VA Contract Census	15	5	0	0	- 100.0%
Total Medicaid Census	3,571	3,497	3,517	3,498	+ 0 .0%
Total Medicare Census	782	761	696	728	+ 4.4%
Total Census	6.061	5,996	5,963	5,967	- 0.5%

Note that from January 1997 to February 1997, the total census dropped from 6,061 to

5,996 people in these long-term care facilities. During that 30 day period, the Medicaid census fell by 74 people (-2.1 percent) and the Medicare census dropped by 21 people (-2.7 percent). In 1998, however, that trend has been reversed. The total census in January 1998 was 5,963 people. In February 1998 it climbed to 5,967 people. The monthly change in the Medicaid census showed a drop of a mere 19 people or 0.5 percent; considerably less than the rate of decline experienced in 1997.

The Medicare census actually jumped — from 696 to 728 individuals. That equates to a 4.6 percent increase. At that rate, the Medicare census would swell by 55.2 percent (or 384 individuals) during 1998. But the longer former venipuncture patients go without medical and personal care services, the more their conditions are likely to be exacerbated. Growth in this census segment could jump at considerably sharper rates. That scenario, of course, would send the cost of taxpayer-provided care skyrocketing.

A spokesperson for Heritage Management, the largest of Utah's nursing facility operators which currently claims 20 percent of the market, said the company's census grew four percent from January 1998 to February 1998. Occupancy rates jumped nearly 10 percent during that period.

Rocky Mountain Care's facility in Clearfield filled its eight available beds from January to February 1998 and now has a waiting list. It's West Valley City facility also admitted eight new residents; all of whom were former clients of the corporation's home health division. Administrators for that small facility called their 30-day admit rate "high.".

With that rate of growth, and Utah's moratorium on additional beds, it may not be too long before facilities cannot accept new admissions.

Projections would indicate the Beehive State is moving towards a crisis in long-term care. There will be too few available nursing facilities — and prohibitive costs when care can be secured — if Medicare benefits are not reinstated for venipuncture and other patients who can, and should, receive care in the comfort and convenience of their own homes.

UAHHA recommends immediate and comprehensive study of the venipuncture issue. It may be better to allow venipuncture benefits for certain classes of patients such as those receiving diabetic care or blood thinner medications. Specific controls, rather than blanket prohibitions, seem more logical in regard to the venipuncture benefit.

IPS Cost Limits and Per-beneficiary Limits

Two provisions of the BBA have a major impact on Utah's home health agencies. These are the reduction in per-visit cost limits and the establishment, under HCFA's Interim Payment System (IPS), of aggregate annual per-beneficiary limits. Combined, these two provisions significantly reduce payment for home health services and will result in reduction of services provided to Medicare beneficiaries.

IPS was developed as a cost-control device geared toward equalizing payments to agencies. It does not, necessarily, address quality issues. Its payment limits do not adequately reimburse providers for the care their patients need. Most Utah agencies are being forced to slash their costs. Most have reduced their staffs by at least 10 percent within the last six months. Others have closed their doors or been forced to merge with other agencies. A majority of the agencies report they have had to severely slash the amount of services they provide to survive under the new payment limits.

The limit is based on fiscal year 1994 data which, for most providers, will reflect five-year old (1993) data. Many agencies are providing a broader range of services than they did five years ago. Many are caring for more complicated cases. These changes are not reflected in the limit.

The limit is further reduced, from these already "too low" rates, by another two percent and by disallowing for the cost of inflation that occurred between 1993 and 1996.

The BBA does not allow providers or patients to appeal the limits or request an exception from them. Patients with exceptionally heavy care needs may be turned away because the agency's limit won't cover the cost of that individual's care.

Patients who need the most care are most severely impacted by the cutbacks. With lower Medicare payments, as mentioned, providers have been forced to trim personnel. They often do not have the staff to administer care to all who need it. Furthermore, the patients who need care the most will either do without it or be served in more costly settings, i.e., emergency rooms, hospitals, or nursing facilities.

Although the new payment system went into effect on October 1, 1997, HCFA did not publish the new beneficiary limits until just this month. At least one mid-sized Utah agency has been forced to operate for six months without knowing its reimbursement limits. This has forced it to function under a "worst case scenario" business plan. It has eliminated services, discharged patients, downsized its administrative and clinical staffs, and consolidated offices. It is still trying to determine if it will be possible to continue operations through the year.

Some state and local government officials have expressed concern, to our Association, about Medicare home health cuts. They see federal budget cutting within Medicare shifting costs to state Medicaid programs. Unfunded mandates, to the states, are always a concern to these elected and appointed individuals.

Finally, Utah families will be particularly hard hit by the loss or reduction of home health services. Women, who are the primary caregivers, will be shackled with the greatest burden in caring for vulnerable newborns and the state's oldest, sickest, poorest, and most frail Medicare beneficiaries.

UAHHA recommends that IPS be abandoned with HCFA moving directly to the Prospective Payment System that the industry, Congress, and the Administration all agree is the preferable program. It appears the venipuncture prohibition and agencies' posturing to live within

the mandates of IPS have already saved the federal government more than was originally required under the BBA. The Association questions the wisdom of continuing IPS with its inherent drawbacks to patients and providers.

Barring that option, however, IPS should embrace data from 1995 or an agency's last settled cost report to determine per-beneficiary caps and per visit cost limits. Even a quick analysis shows that would better serve patients and agencies; particularly the newer Utah agencies which were not in business in 1993. These companies must use national figures which, in some cases, can slash per-beneficiary limits as much as 65 percent!

Surety Bonds

Despite the postponement of the Medicare requirement for each home health agency to obtain a surety bond as mandated by the BBA, many problems still exist. Utah's largest and hospital-based agencies will likely have few problems complying with the bonding requirement. The bulk of the state's agencies, however, are freestanding, not-for-profit, small, and/or rural operations. These are experiencing considerable difficulty in obtaining surety bonds under the guidelines as initially established. It was estimated as many as 85 percent of home health agencies across the U.S. were unable to purchase bonds under the original regulation.

While HCFA plans to modify the regulation, many problems continue to plague the home health industry regarding surety bonds. These include:

1. Home care agencies in good standing with the Medicare and Medicaid programs are not exempted from the requirement. It was the intent of Congress and the Administration to use surety bonds to discourage "fly-by-night" operators from entering or participating in the programs. But established, reputable agencies are being forced from the programs due to high, unreimburseable participation costs.

2. HCFA crafted the surety bond regulation to serve as insurance against any loss through overpayments to agencies. Since only two-tenths of one percent of all Medicare home care payments are unrecouped overpayments — according to HCFA's own data — this is a gross overreaction to the problem.

3. The cost of the bonds is not reimbursable. Medicare-certified agencies are reimbursed at cost of less for providing care. If the cost of the bond is not reimbursed, it will be forced to use resources that should go for patient care to cover premium costs.

4. The bond amount minimum is $50,000, but no ceiling has been set. Regulations indicate as much as 15 percent of an agency's Medicare and Medicaid revenues must be covered by a bond. That can make the cost of the surety bond prohibitive.

5. Agencies wishing to participate in Medicare and Medicaid must renew their bonds every year. Making the premium an annual expense makes it even more prohibitive.

6. Agencies are required to hold separate bonds for the Medicare and Medicaid programs, thus duplicating their expenses.

7. The bonds require personal guarantees and collateral that many owners and voluntary, non-profit agencies are not able to meet. Some Utah agency owners are being asked to personally guarantee up to two or three times the amount of the bond, totaling millions of dollars.

8. In cases of overpayments, the bond companies can become the payor of first resort rather than allowing the home care agencies to agree to a repayment plan.

9. Repayment will be demanded prior to expiration of an agency's appeal rights. HCFA is allowed to demand payment from the surety before an agency's right to appeal an alleged overpayment has expired. A majority of overpayments related to denial of coverage are routinely overturned on appeal.

10. HCFA failed to conduct a meaningful analysis of the impact of the bond requirement on small business. This is particularly concerning since 94 percent of home health agencies are small businesses; many of them operated by women and minorities.

Like Congress, UAHHA is concerned about unscrupulous providers and losses in the Medicare program from overpayments. However, surety bonds are an inappropriate way to recoup those funds. The surety bond requirement should be dropped, or significantly modified, to keep legitimate agencies from losing their Medicare beneficiaries as clients.

Restricted Patient Referrals and Care Plans

Because of memos and advisories issued by HCFA to physicians regarding fraud, abuse, personal liability, and new regulations, Utah's home health agencies have noted a substantial decrease in patient referrals. As noted before, the demands of IPS, the venipuncture prohibition, and a recent dearth of referrals have shrunk home care companies' Medicare business as much as 35 percent since January 1, 1998.

Doctors are reluctant to sign plans of care and work with agencies in managing clients. This, to a marked degree, is due to the physician seeing no revenue for his or her efforts. It takes too much time to document and bill Medicare for case management.

Greater cooperation and communication is needed between HCFA, physicians, and home health personnel to stem the growing problems regarding referrals for in-home services. Federal studies and/or initiatives are also needed to safeguard patient care while limiting physician and home health provider liability.

Beta Factor

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Telephone 782-9080

Debbie Boyle RN
Betty Jeffery RN

March 19. 1998

Senator Conrad Burns
187 Dirksen Senate Office Building
Washington, DC 20510-2603

Dear Senator Burns:

This letter is in regards to the issue of Surety Bonds being required by Home Health Agencies in order to participate in the Medicare-Medicaid program. We are being required to have $100,000 in Bonds to continue participation in a program that we received $270,000 from last year. The requirement states we need a $50,000 bond for Medicare but also another $50,000 bond to continue caring for Medicaid patients. We did $26,000 of Medicaid revenue last year. We have been in the Home Health business for the last eleven years and have never had a large overpayment to Medicare. For the last two years Medicare has underpaid us by $20,000.

We feel that if the bonds are to be required they should be based on a Company's revenues. We also feel that agencies that have been in the program five years or longer should be grandfathered. There has been little, if no, fraud and abuse in Montana and we feel our rural agencies are paying for the fraud that has occurred in Florida, California, and Texas. Because of our Certificate of Need process and yearly State surveys, Montana agencies are kept in compliance with Medicare rules and conditions of participation. I would like to know who issued Provider Numbers to these agencies who bilked the Medicare program. They were not being monitored by their States and seemed to fall through the cracks in regards to fraudulent billing. Who is responsible for that?

I would also like to address the fact that the Medicare program no longer reimburses agencies for venipunctures, saying it is not a skilled need. This rule affected ten of our fifty clients. These clients who were homebound and on coumadin, a blood thinner, had to be discharged. Many do not have family available to monitor their medication or make arrangements for lab draws every 2-4 weeks. I had a 78-year-old woman, with no family here, who was going to try to walk to the lab to have her lab drawn. She has 25 steps to her house, walks with a cane due to residual weakness from a past CVA, she also has a frozen left shoulder from arthritis and has only limited movement of her left arm and hand. This woman can barely walk from her kitchen to her living room approximately 50 feet.

Another client who was getting protime draws is 87 years old, blind, walks with a walker and needs the assistance of at least one person. The only way her daughter can get her to the Doctor's office is by ambulance. Her daughter is a schoolteacher who works 7:30 AM to 4 PM. Monday thru Friday.

These are examples of the patients this rule has affected. Most patients who have venipuncture requirements are on medications like coumadin or lanoxin and need to be strictly monitored. We feel these patients who have diagnoses such as atrial fibrillation or CVA's will neglect to have their lab work done and will end up in the hospital or worse with a massive stroke or heart attack.

Home Health has proven to be cost effective. Does $70.00 for a nurse to do a lab draw compare with $1000.00 for one day on a medical floor at the local hospital? I will mention that these people who were receiving lab draws also had to qualify for the Medicare benefit by being homebound and were having changes in their medications. They were not just a monthly lab draw with stable medications.

I would hope that HCFA will reconsider Surety Bonds and the requirements to obtain a bond and also reinstate venipunctures as a covered service to those who desperately need them.

Sincerely,

Deborah A. Boyle R.N. B.S.N

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March 24, 1998

Honorable Conrad Burns
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187 Dirksen Senate Office Building
Washington, DC 20510

Attn: Paul Van Remortel

Re: HCFA Home Health Agency Surety Bonds

Dear Sir:

The actual procurement of the surety bond, at least for us, was of limited hassle considering the initial government requirements and the short time frame.

It would appear that this requirement could have been more thought out before it was issued. However, let me make some further observations.

1. We decided to discontinue our participation in the Medicaid Home Health program because we do such little Medicaid business. We could not justify the added cost ($240 annually) for less than $4,000 in revenue billed.

2. I would suggest that for us smaller agencies (under $200,000 annual billed revenue) that the surety bonding requirement be changed to "15% or $50,000 whichever is the least". Obviously I am insuring against a much larger percentage potential loss since I have to bond for $50,000.

3. Why are government agencies exempt? We all treat and/or compete for the same clients and at times are certainly in the same financial situations.

Thank you for this opportunity to express my concerns.

Sincerely,

James M. Holcomb

James M. Holcomb
Administrator

Partners
In Home Care, Inc.
Bringing Health Care Home

March 24, 1998

Mr. Paul Van Remortel
C/O Senator Conrad Burns
United States Senate
Washington D€ 20510-2603

Dear Paul,

Thank you and Mr. Burns for meeting with the Montana Association of Home Health Agencies last week. Our discussion focused on several of the adverse effects of the Balanced Budget Amendment on home care patients. The hearing called by Senator Grassley set for March 31 will provide you with information concerning the effects of the venipuncture elimination and the Interim Payment System.

Regarding correspondence to our agency from Senator Burns about surety bonds, and his request for information about the status of our agency's success in obtaining a bond. We have a bond in place for both Medicare and Medicaid. We had no trouble getting the bond. We are a non-profit agency, with literally no assets with which to secure the bonds, but we secured them anyway. To ensure our success, our sponsoring hospitals (both non profit) guaranteed the bonds. The cost, approximately $1000 is non-reimbursable to our already non-profit agency. We will have to fund raise and use charity dollars to make up this difference.

Additionally, it is my understanding that about 4 Home Care programs in Montana are opting out of obtaining surety bonds for Medicaid. Even though they don't serve much Medicaid to make it worthwhile, Congress has just offered licensed providers a legal means to opt out of serving Medicaid patients. The licensure laws prohibit such discrimination.

Our agency has not had a Medicare overpayment. In fact, Medicare historically has owed our agency from $40,000 to $135,000 in underpayments! In general, the Medicare program will eventually pay the money owed to the agency, but only about 85% of it is paid, nearly 18 months after the agency has incurred the cost of providing the service. Medicare already has a methodology in which to withhold certain monies from Home Care providers, and uses it regularly. The additional $1000 cost to an agency that has not had an overpayment back to Medicare, while withholding settlements already due to them via settled cost reports is a double financial burden.

Again, thank you and the Senator for your time.

Respectfully yours,

Nancy Heyer

Nancy Heyer, RN
Director of Home Health Services

Telephone: (406) 728-8848 · FAX: (406) 549-8970
500 North Higgins Avenue, Suite 201 · Missoula, Montana 59802-4535

NORTHERN MONTANA Hospital P.O. Box 1231 30 Thirteenth St. Havre MT 59501 (406) 265-2211

March 26, 1998

Mr. Paul Van Remortel
Office of Senator Conrad Burns
183 Dirksen Senate Office Building
Washington, DC 20510

Dear Mr. Van Remortel:

We appreciate the letter from Senator Burns dated March 9, 1998 regarding solicitation of feedback as to the Healthcare Financing Administration's (HCFA) regulation on surety bonds for home health care agencies. We remain concerned about the surety bond on two primary issues.

First, HCFA does not allow the cost of acquiring a surety bond, either from Medicare or Medicaid participation, to be claimed as an allowable cost on the Hospital Cost Report. Though HCFA requires the surety bond for participation in the Medicare/Medicaid programs, these costs would not be considered allowable and would not be recognized by HCFA. Therefore, these costs must be passed on in the form of a **hidden tax** to those patients who either have insurance or pay for the bill themselves. As north-central Montana is of an agricultural-based economy, the cost of the surety bond is primarily being passed on to the farm and ranch families.

The second issue of concern is the lack of ability of a provider to post a security in the face amount of the acquired surety bond in lieu of the surety bond. Posting a security with a value equal to the amount required would provide the level of security HCFA is requiring, allow the provider to earn interest on that investment, and significantly lower the cost of compliance for providers.

I appreciate the opportunity to address our concerns regarding the surety bond. I would be happy to discuss these issues with you personally. Please feel free to contact me directly at (406)262-1141.

Sincerely,

Randall D. Arlett
VP/Finance & Business Services

RDA:hlm

Our Family ... Caring for Yours!

UTAH ASSOCIATION OF HOME HEALTH AGENCIES

6075 S. Highland Drive, Suite B • P.O. Box 71348 • Salt Lake City, Utah 84171-0348
Telephone (801) 277-7084 • FAX (801) 273-8015

March 30, 1998

The Honorable Orrin G. Hatch
United States Senate
Washington, DC 20510

Dear Senator Hatch:

Constituent visits with you and other members of Utah's Congressional delegation, earlier this month, examined a myriad of issues inherent with the Balanced Budget Act of 1997 and the Medicare program. During these discussions, representatives and members of the Utah Association of Home Health Agencies (UAHHA) were petitioned for a concise, personal perspective of the challenges currently confronting home care providers and their clients.

The accompanying document is an initial attempt at fulfilling those requests of elected officials and their staff liaisons. It is also submitted, through your office, as written testimony before the Senate Special Committee on Aging chaired by Senator Charles Grassley, R-Iowa. Robert D. Foreman, Deputy Staff Director for Health Policy in your office, has agreed to facilitate submission of this material.

While this forum cannot adequately portray the scope or urgency of the situation, it is submitted for consideration along with requests for (1) examination of additional data as it becomes available, (2) continuing dialog with industry representatives, and (3) timely Congressional action to insure the integrity of Utah's home health agencies and uninterrupted, quality care for the state's frail and elderly citizens.

Thank you for your continued interest in the home health industry and support for Utah's ever-growing senior and at-risk populations.

Sincerely,

UTAH ASSOCIATION OF HOME HEALTH AGENCIES

Steven Hansen
Executive Director

Enclosure

Hearing before the
Senate Special Committee on Aging
on The Impact of the Balanced Budget Act on Medicare Home Health Services
March 31, 1998

MATERIALS FOR THE RECORD

SEN. CRAIG

1- Does your estimated cost of a surety bond ($2,280) take into account other requirements of surety companies, such as collateral or personal guarantees?

A: No. This figure represents the cost of surety companies' underwriting charges and is based on estimates we received from representatives of the Surety industry. They estimated the net cost of the underwriting to the HHAs to be approximately $10.00 for every $1,000 of the amount of the surety bond.

Has your agency taken steps to estimate the impact of these types of requirements on home health agencies, particularly smaller agencies?

A: Based upon information available when we prepared the final rule that was published in the January 5, 1998 *Federal Register*, we estimated an average annual bond cost of approximately $1,200 per HHA.

As you know, concerns about the potential liability of a surety company have been raised since the January 5 publication of the final rule. Uncertainties on the part of the Surety industry concerning the extent of their liability have resulted in a less than fully robust market for obtaining bonds. Those uncertainties may also have resulted in some sureties asking for high collateral amounts from HHAs. On March 4, we published two documents in the *Federal Register*, which announced our intent to make technical changes. These changes are in keeping with standard industry practice and should help surety companies offer bonds at more affordable prices to all agencies, including small agencies, by providing a more precise and limited time frame for which bond writers are liable.

We are working towards the publication of a final regulation containing these changes. Given the scope of the changes, HHAs will be given 60 days from the date of publication of the new final regulation to submit a surety bond.

2- Are there any preliminary statistics on what percentage of agencies can and do get surety bonds?

A: As of mid-April, approximately 35 percent of all HHAs participating in Medicare had secured surety bonds. We expect this percentage to substantially increase with the implementation of the technical changes announced in the March 5 *Federal Register* and the publication of the final rule.

3- HCFA has said that no one will lose venipuncture services, because Medicare covers this service by a lab technician under Part B. How will the 2.1 million Part A only Medicare beneficiaries receive venipuncture services?

A: Beneficiaries with only Part A coverage who only need venipuncture can obtain this service in the same way they obtain other Part B services, usually through other private insurance. However, most beneficiaries who are receiving home health care now will not be affected by the venipuncture provision. Their conditions generally would require another skilled nursing service, such as observation and assessment, monitoring effects of and compliance with complex medication changes, wound care, or other nursing services. They may also qualify for home health based on the need for other skilled services such as physical therapy or speech language pathology.

Also, if a beneficiary needs a skilled service in addition to blood draws and meets the qualifying criteria for the home health benefit, he or she will continue to receive home health care. The Medicare home health benefit will also continue to pay for blood draws when a beneficiary qualifies for the benefit based on the need for another skilled service.

What has HCFA done to address this problem in underserved areas where at-home lab services are not available?

A: Our Atlanta Regional Office recently coordinated a survey of our Medicare carriers and intermediaries on our current venipuncture travel reimbursement policies. In that survey, no contractor reported any homebound beneficiaries who were not able to obtain venipuncture services after assistance from our beneficiary services staff or on their own. However, we are concerned that a potential access to care problem exists in some rural areas.

Therefore, we are in the process of revising our venipuncture travel reimbursement and specimen collection fees. Currently under Medicare Part B, a laboratory is reimbursed $3.00 for each specimen collected and can be reimbursed for travel under either a flat rate travel allowance or a per mile rate. In the past,

contractors established their own travel allowances based on local conditions.

We plan to raise the specimen collection fee to $4.00 for each specimen, and we are instructing our contractors to adopt a minimum one-way travel allowance of $7.52, or a minimum per mile travel reimbursement of 75 cents a mile. The flat rate reimbursement is to be pro-rated for collections of more than one specimen at a single site of service such as a nursing home. The per mile method is used in areas where access to care is an issue. Both types of travel allowance are based on the current federal mileage rate and an amount per mile for the lab technician's time and overhead. We plan to review and update the minimum travel allowance annually as needed.

4- What has HCFA done to educate Medicare beneficiaries and providers about the interim payment system?

A: On February 3, 1998, the HCFA Administrator wrote to all Medicare Home Health Agencies (see Attachment), advising them that under the provisions of the Balanced Budget Act of 1997, the Secretary of Health and Human Services is required to establish an interim payment system while a prospective payment system is developed. The letter contained the provisions of the interim payment system, the rationale for the interim payment system, and HCFA's expectation that HHAs will balance the cost of caring for any one patient against the cost of caring for all patients so that all Medicare enrollees can be safely and effectively cared for. The letter also stated, "Any reports of HHAs misinforming beneficiaries or inappropriately terminating care for Medicare enrollees will be considered the basis for a complaint survey that could lead to termination of the HHA from Medicare."

The interim payment system is a control on HHA costs and not on coverage or services to beneficiaries. There should be no special impact on needed services to beneficiaries. For this reason, we have limited our education efforts to our contractors and providers.

5- I have been hearing that the effect of IPS will fall most heavily on the sickest and most frail Medicare patients. Is IPS having the unintended consequence of hurting beneficiaries?

A: Beneficiaries eligible for the home health benefit should be able to receive the care they need under the interim payment system. The interim payment system does, for the first time, create incentives for home health agencies to provide care efficiently. Because the new limits are applied in the aggregate to the count of patients and are based on the agencies' actual costs in FY1994, HHAs have the

flexibility to provide the appropriate duration, number and skill level of visits to each patient within these limits. The limit will reflect the mix of patients, including both high and low cost, that are cared for by the agency.

Our Regional Offices will investigate cases where an HHA tells a beneficiary that it will reduce the amount of care because of these provisions of the Balanced Budget Act. If It is determined that a patient's rights have been violated, HCFA will treat this as the basis for a complaint survey, which could lead to penalties and even termination of the agency from the Medicare program.

6- **Would the Administration be willing to propose or to work together with the leadership in Congress to make changes to IPS this session?**

A: Congress enacted a proposal that reflected the best collective judgement about how to achieve the necessary savings in the fairest way possible. If a consensus in Congress can agree on a legislative proposal to address recently articulated concerns about the interim payment system, while maintaining the savings anticipated by the Balanced Budget Act of 1997, HCFA would be willing to provide technical assistance.

SEN. SHELBY

1- **HCFA had said that the venipuncture provision in last year's Balanced Budget Act would not cause individuals with serious health ailments to lose their home health care. When beneficiaries have lost their care, HCFA has advised them to ask their physician to re-order home health care under a different qualifying skilled need. Nonetheless, I have constituents who have followed HCFA's advice and still have fallen through the cracks. How do you reconcile how HCFA has portrayed the venipuncture issue versus the anecdotal evidence I have received from my constituents?**

A: While we have made efforts to prevent this from happening, such lapses could be due to the misunderstandings of patients, their physician, home health agencies, or even our contractors. We have worked with our contractors and providers to assure that they are aware of the options for continuation of coverage. For example, we sent written guidance to all contractors to create a common understanding of Medicare home health policy in light of the venipuncture provision (attached). The guidance states, "We [HCFA] believe there are some beneficiaries who had been receiving home health care with venipuncture as the qualifying service who may, in fact, have medical situations complex enough to qualify for home health due to a need for other types of skilled nursing services, including observation and assessment or management and evaluation."

In addition, it is important to remember that Medicare, by statute, does not cover long term care or personal custodial services when they are not related to specific medically necessary treatments. Some of your constituents may require long term or personal care which is not covered under Medicare law.

2- **One explanation I have been given is that the fiscal intermediaries who administer the program may be interpreting the BBA provision differently than HCFA. Have you seen any indications of this? Does HCFA have the authority to force the intermediary to interpret the BBA provision "correctly"?**

A: HCFA administers the Medicare program and thus has the authority to require its contractors, in this case the six Regional Home Health Intermediaries, to adhere to the guidelines that we establish. We are aware that there has been some misunderstanding surrounding the interpretation of the venipuncture provision. To assure that this provision is applied consistently nationwide, we provided an initial briefing for our contractor staff on this issue as well as more detailed follow-up discussion between contractor medical review staff and HCFA physicians and medical review experts. Further, as I mentioned in the answer to

the previous question, we sent written guidance (attached) to all contractors to create a common understanding of Medicare home health policy in light of the venipuncture provision. We believe these actions should avoid any further misunderstandings among our contractors of the proper way to implement this provision.

3- **It is my understanding that the reimbursement to Medicare Part B providers for venipuncture services is many times insufficient, especially in rural states like Alabama. Has HCFA begun to make adjustments in the reimbursement of these services so providers find it worth their while to provide them?**

A: While we believe that most beneficiaries will have no problem having their blood drawn under the venipuncture provision, there may be some areas of the country where blood specimens are more difficult to collect.

We plan to raise the specimen collection fee to $4.00 for each specimen, and we are instructing our contractors to adopt a minimum one-way travel allowance of $7.52, or a minimum per mile travel reimbursement of 75 cents a mile. The flat rate reimbursement is to be pro-rated for collections of more than one specimen at a single site of service such as a nursing home. Therefore, the payment for specimen collection and travel will increase from $6 for a round trip to a minimum of $19.04. We plan to review and update the minimum travel allowance annually as needed.

In addition, physicians who order lab tests for homebound beneficiaries may arrange for other practitioners (e.g., nurse practitioners, physician assistants, or clinical nurse specialists) to draw blood. They would conduct a home visit, draw blood when they examine the beneficiary, then bill Medicare for the visit.

4- **In an interview with Eli's Home Care Week, an official from one of HCFA's own Medicare fiscal intermediaries admits "A lot of people are going to fall through the cracks" as a result of the elimination of venipuncture as a qualifier. After February 5, it's too bad, so sad."**

a) HCFA has said that the venipuncture exclusion would not adversely affect patients. How do you square HCFA's statements with what the intermediaries are saying?

A: HCFA was shocked at the statements attributed to an employee of our contractor. We contacted Palmetto GBA immediately upon hearing of the Eli article. We have been assured that the statements apparently made by their employee did not represent the attitude or position of Palmetto GBA. Palmetto

GBA is one of the six Regional Home Health Intermediaries that process Medicare home health agency claims nationwide. In addition, the HCFA Administrator followed up with the management of this contractor to assure that the need for corrective action is fully understood.

Medicare Part B allows payment of a fee for specimen collection and a travel allowance for the costs of transportation and the costs of trained personnel to collect specimens for clinical diagnostic lab tests from homebound patients.

b) Were any studies done to determine the impact of this provision on patients? How many patients did HCFA estimate would be affected by this provision?

A: The impetus for the venipuncture provision was provided by Operation Restore Trust (ORT), one of the Administration's initiatives to combat fraud and abuse. As a result of ORT, medical staff at HCFA's contractors discovered that some physicians used the monitoring of blood as the sole reason for ordering home health services. The venipuncture provision targets this inappropriate use of home health services. There were no quantitative estimates made as to the number of Medicare beneficiaries that would be affected.

5- **HCFA has advised use of management and evaluation as a qualifying need. In the same Eli interview, the fiscal intermediary warns home health agencies against using management and evaluation as a qualifying need. Observation and assessment, the official concludes, is "not going to be the catch-all."**

a) How do you square HCFA's statements with those of the intermediaries? Isn't there a serious disconnect between what HCFA is saying and what the intermediaries are actually doing in processing claims?

A: In addition to the actions described in the answer to the previous question, we have released further written guidance to all the Regional Home Health Intermediaries to assure that there is consistent and proper understanding of relevant coverage provisions. This guidance is attached.

b) Were studies done to determine how many Medicare patients were receiving venipuncture as their sole skilled service?

A: No, we have not done such studies.

6- **HCFA has indicated that no one will lose venipuncture services, because Medicare covers this service by a lab technician under Part B.**

a) 2.1 million Medicare beneficiaries have Part A but not Part B of Medicare? How will they receive venipuncture services?

A: Beneficiaries with only Part A coverage who only need venipuncture can obtain this service in the same way they obtain other Part B services, usually through other private insurance. However, most beneficiaries who are receiving home health care now will not be affected by the venipuncture provision. Their conditions generally would require another skilled nursing service, such as observation and assessment, monitoring effects of and compliance with complex medication changes, wound care, or other nursing services. They may also qualify for home health based on the need for other skilled services such as physical therapy or speech language pathology.

Also, if a beneficiary needs a skilled service in addition to blood draws and meets the qualifying criteria for the home health benefit, he or she will continue to receive home health care. The Medicare home health benefit will also continue to pay for blood draws when a beneficiary qualifies for the benefit based on the need for another skilled service.

b) In many parts of the country, particularly in rural/under served areas, at-home lab services are not available because of long travel times, security concerns, lab technician regulations, and low reimbursement. What has HCFA done to address this problem?

A: Our Atlanta Regional Office recently coordinated a survey of our Medicare carriers and intermediaries on our current venipuncture travel reimbursement policies. In that survey, no contractor reported any homebound beneficiaries who were not able to obtain venipuncture services after assistance from our beneficiary services staff or on their own. However, we are concerned that a potential access to care problem exists in some rural areas.

Therefore, we are in the process of revising our venipuncture travel reimbursement and specimen collection fees. Currently under Medicare Part B, a laboratory is reimbursed $3.00 for each specimen collected and can be reimbursed for travel under either a flat rate travel allowance or a per mile rate. In the past, contractors established their own travel allowances based on local conditions.

We plan to raise the specimen collection fee to $4.00 for each specimen, and we are instructing our contractors to adopt a minimum one-way travel allowance of $7.52, or a minimum per mile travel reimbursement of 75 cents a mile. The flat rate reimbursement is to be pro-rated for collections of more than one specimen at a single site of service such as a nursing home. The per mile

method is used in areas where access to care is an issue. Both types of travel allowance are based on the current federal mileage rate and an amount per mile for the lab technician's time and overhead. We plan to review the minimum travel allowance annually and update it as needed.

7- **What impact will the loss of home health aide services have on patients who need them? Won't this result in increased admissions to nursing homes?**

A: The intent of the Medicare home health benefit has always been to cover skilled medical services provided in the home for the treatment of an illness or injury. Custodial care, provided by a home health aide or any other practitioner, does not qualify as the sole basis for Medicare coverage for home health benefits, nor does it qualify as the sole basis for admission to a Medicare-certified skilled nursing facility. There is a large and growing need for long term care services for persons needing only custodial care; however, the Medicare program has never been authorized to meet those needs.

8- **Some patients who lose home health coverage as a result of the venipuncture exclusion will become eligible for Medicaid services after they become impoverished from spending their assets and income on their health needs.**

a) Has HCFA done an analysis of the cost shifting to other programs such as Medicaid that will result from this provision?

b) Doesn't this provision, in effect, impose an unfunded mandate on the states?

A: We have not conducted such an analysis. We identified a class of Medicare abuse through our Operation Restore Trust activities whereby beneficiaries were receiving Medicare home health services that were not medically necessary based solely on their need for venipuncture. Together with the Congress, we moved to eliminate the opportunity for this abuse. The rules of the Medicaid program allow coverage of home health and personal care services that are medically necessary. The rules of the Medicaid program have not changed with respect to home health or personal care services. Such services must be medically necessary and must be provided as part of a medical model of care.

9- **a) Wouldn't it make sense to at least delay the implementation of this provision to ensure that patients receive the care they need while Congress works to address whatever valid concerns may surface about the venipuncture benefits?**

A: Section 4615 of the Balanced Budget Act of 1997, the venipuncture provision, is a change in the law, and , therefore, does not permit latitude in

interpretation, including delaying its implementation.

SEN. FEINGOLD

1- **As I noted in my opening remarks, the Interim Payment System, as currently structured, penalizes low-cost providers for their past efficient provision of service. Is HCFA taking any steps to address this inequity, and what, in your view, can Congress do to make sure these inequities are addressed?**

A: Equity was a major consideration in the design of the home health interim payment system enacted as a part of the Balanced Budget Act of 1997. Currently, there is no available mechanism to measure the severity of home health care patients' illness. Without such a "case-mix" measure, it is impossible to tell if an agency with high historical costs per case was inefficient or if it treated a sicker population. Likewise an agency with low historical costs per case may have been efficient or may have had a lighter case load.

Disparity among agencies will be decreased because rates are blended, with 75 percent of the payment based on an agency's own historical costs per case and 25 percent based on the historical costs per case for the census region in which they are located. This will increase the cap for agencies (in each region) with low historical costs and slightly decrease the cap for agencies (in each region) with high historical costs. The new cap does not discriminate against individual states. Within states, there are agencies with costs above the regional average and agencies with costs below the regional average. Thus, the blending lowers the cap for agencies with costs above the regional average, and the cap for low-cost providers will be slightly higher than their own historical costs. Agencies that were established after FY1994 will have a cap that is based fully on the national median.

2- **According to Valley Visiting Nurse Association in Neenah, Wisconsin, the average, per patient Medicare home care cost in Wisconsin is $2,586, compared to $5,000 or more in other parts of the country. These providers simply don't have any "fat" to cut from their programs. I am hearing that IPS will reduce Medicare payments so dramatically that providers will have to either cut services or even close shop altogether.**

Has HCFA conducted analyses of the expected impact of the Interim Payment System on the quality and accessibility of Medicare home care services on states that already provide efficient, low-cost services?

A: The interim payment system is a control on HHA costs and not on coverage or services to beneficiaries. Therefore, we have not conducted analyses of IPS' impact on beneficiary services.

We believe that beneficiaries eligible for the home health benefit should receive the care they need under the interim payment system. The aggregate per beneficiary limit does not restrict the number of visits to individual patients. The cap simply captures as an average the full range of patients served by an HHA in the base year (1994) giving HHAs the flexibility to provide the appropriate amount of care within that limit. By basing the aggregate limit on the HHAs actual costs, the limit reflects the mix of high and low-cost patients that the agency cares for.

3- **I am still hearing [Wisconsin] that many agencies have not yet been able to secure the necessary Medicare surety bonds. What percentage of agencies have and have not been able to get bonds?**

A: Forty-four percent of the Wisconsin home health providers have submitted bonds (74 of the 169 agencies) to United Government Services, the Regional Home Health Intermediary. This includes freestanding, provider based, and chain providers. We expect many more to obtain bonds once we publish the final regulation clarifying bond writer liability.

Hearing before the
Senate Special Committee on Aging
on The Impact of the Balanced Budget Act on Medicare Home Health Services
March 31, 1998

MATERIALS FOR THE RECORD

SEN. REED was promised an analysis of the impact of home health interim payment system on Medicaid, various programs designed to help seniors stay in their homes, and nursing homes and how different alternative proposals might affect Rhode Island in particular. (P. 42-44)

A: We have no specific analysis of these issues. The assertions that the interim payment system would result in wholesale discharges of persons from Medicare home health agencies are based on the premise that home health agencies will be unable to balance the high cost of their sicker patients with the lower cost of their healthier patients and will terminate care for their higher cost Medicare beneficiaries. We have notified all Medicare home health agencies that "Any reports of HHAs misinforming beneficiaries or inappropriately terminating care for Medicare enrollees will be considered the basis for a complaint survey that could lead to termination of the HHA from Medicare." [See attached notification letter.]

Impact on state programs:
We believe that State Medicaid agencies and other state programs would be unlikely to pay for services while an individual was receiving all medically necessary care from a Medicare home health agency under the plan of treatment required in the regulations. There should be no special impact on needed services to beneficiaries resulting from the interim payment system, which assumes that Medicare home health providers will continue to provide services to all beneficiaries needing care and only eliminate excess services.

To the degree that a Medicaid program does provide home health care services not provided by a Medicare home health agency for a dually eligible beneficiary, it is likely that Medicaid would have had to pay for the care of that beneficiary at a later point. In that case, there would be little net additional cost, only the assumption of cost at an earlier point.

Medicaid agencies vary considerably in their capacity to provide long term care services. Any attempt on our part to project national numbers in the varied and changing context of Medicaid long term care would be highly conjectural.

Impact on nursing home costs:
We believe that the interim payment system is unlikely to have a significant impact on nursing home costs is because beneficiaries and their families generally avoid

institutionalization if they can. While the effect of the home health caps are significant for some agencies, they will be relatively modest for other agencies. Therefore, a patient who was having difficulty obtaining services from one home health agency would be more likely to shift to another home health agency than to seek Medicaid nursing home placement.

Effect on Rhode Island:
Equity was a major consideration in the design of the home health interim payment system enacted as a part of the Balanced Budget Act of 1997. Currently, there is no available mechanism to measure the severity of home health care patients' illness. Without such a "case-mix" measure, it is impossible to tell if an agency with high historical costs per case was inefficient or if it treated a sicker population. Likewise an agency with low historical costs per case may have been efficient or may have had a lighter case load.

Disparity among agencies will be decreased because rates are blended, with 75 percent of the payment based on an agency's own historical costs per case and 25 percent based on the historical costs per case for the census region in which they are located. The new cap does not discriminate against individual states. Within states, there are agencies with costs above the regional average and agencies with costs below the regional average. Thus, the blending lowers the cap for agencies with costs above the regional average, and the cap for low-cost providers will be slightly higher than their own historical costs. Agencies that were established after FY1994 will have a cap that is based fully on the national median.

In my response to your question during the Committee's March 31 hearing, I agreed to try to monitor the situation in Rhode Island and some of the New England states where there might be some increased costs. This is because other systems exist there through Medicaid or other community or State funding to provide services for people who might not qualify under Medicare. I will keep you advised of any findings from our monitoring attempts.

If a consensus in Congress can agree on a legislative proposal to address recently articulated concerns about the interim payment system, while maintaining the savings anticipated by the Balanced Budget Act of 1997, HCFA would be willing to provide technical assistance to analyze the impact of those proposals on Rhode Island and other states.

SEN. BURNS was promised an update on HCFA's efforts to determine whether we could require just one bond for both Medicare and Medicaid. (P. 47)

A: At this time, we are continuing to explore whether there is a way to interpret the statute in a way that would allow home health agencies to do business with Medicare and Medicaid under one surety bond. When we have that answer, I will advise the Committee on our findings.

SEN. COLLINS was promised an update on HCFA's inquiry into whether travel or reimbursement for venipuncture should be raised. (P. 54)

A: We are in the process of revising our venipuncture travel reimbursement and specimen collection fees. Currently under Medicare Part B, a laboratory is reimbursed $3.00 for each specimen collected and can be reimbursed for travel under either a flat rate travel allowance or a per mile rate. In the past, contractors established their own travel allowances based on local conditions.

We plan to raise the specimen collection fee to $4.00 for each specimen, and we are instructing our contractors to adopt a minimum one-way travel allowance of $7.52, or a minimum per mile travel reimbursement of 75 cents a mile. The flat rate reimbursement is to be pro-rated for collections of more than one specimen at a single site of service such as a nursing home. Both types of travel allowance are based on the current federal mileage rate and an amount per mile for the lab technician's time and overhead. Therefore, the payment for specimen collection and travel will increase from $6 for a round trip to a minimum of $19.04. We plan to review and update the minimum travel allowance annually as needed.

SEN. BREAUX was promised a list of providers required to obtain surety bonds under the BBA. (P. 70)

A: The following providers are required to obtain surety bonds under the BBA:

- Durable medical equipment, prosthetics, orthotics and supplies suppliers (a proposed regulation was published and the comment period is closed; we expect to publish the final regulation in the Fall),
- Home health agencies (regulations were published January 5, 1998),
- Comprehensive outpatient rehabilitation facilities (working on the proposed regulations), and
- Rehabilitation agencies (working on the proposed regulations).

DEPARTMENT OF HEALTH &HUMAN SERVICES

Health Care Financing Administration

6325 Security Boulevard
Baltimore, MD 21207 – 5187

DATE: APR 7

FROM: Director, Chronic Care Purchasing Policy Group, CHPP
Director, Program Integrity Group, OFM

SUBJECT: Skilled Nursing Care under the Medicare Home Health Benefit

TO: All Regional Administrators
All Medical Directors, RHHIs

Purpose

This memorandum is to reaffirm current Medicare policy regarding skilled nursing care as a qualifying service for the home health benefit. The purpose is to create a common understanding of certain aspects of current Medicare home health policy in light of the venipuncture provision in the Balanced Budget Act of 1997 (BBA).

Background

As you know, to receive reimbursement for home health care a beneficiary must be under the care of a physician who has certified that medical care in the home is necessary and who has established a plan of care for the beneficiary. The beneficiary also must be confined to the home and must need intermittent skilled nursing services, physical therapy or speech language pathology, or have a continuing need for occupational therapy. The venipuncture provision in the BBA, Section 4615, removes blood draws from the list of skilled nursing services that qualifies a beneficiary for home health care. Venipuncture is the withdrawing of venous blood, typically used for analysis of the blood sample. (The Addendum will address specific questions about whether certain procedures are considered to be venipuncture.) If the beneficiary **only** needs blood drawn, he or she will not qualify for the home health benefit. However, if an individual requires skilled therapy or nursing services, he or she can continue to receive home health services, including venipuncture.

Medicare still pays for blood draws under Part B. Under section 1861(s)(3) of the Social Security Act (the Act), beneficiaries who only need their blood tested on a regular basis can continue to have their blood monitored. In addition, if a physician determines that a beneficiary is unable to travel to a laboratory or the physician's office for the blood draw, Medicare Part B will pay for the specimen collection and travel by a technician to the beneficiary's residence under Section 1833(h)(3) of the Act.

Recently, HCFA responded to a letter from Representative Bill Thomas, Chairman of the House Subcommittee on Health, which presented several clinical case studies concerning the venipuncture provision. Our response reflects current Medicare policy on home health skilled services, which will be explained below in more detail. This response does not reflect new policies, just application of the current policy principles to the case studies relying upon informed clinical assumptions about the patients in the study. All decisions regarding coverage or eligibility must be made based upon all established policies and in the context of full knowledge of the individual medical status of the beneficiary.

Skilled Nursing Care as a Qualifying Service for the Home Health Benefit

It is reasonable to expect that some beneficiaries receiving home health, where venipuncture was the previous qualifying service, have medical situations that appear medically complex enough to qualify for other skilled nursing services. Section 205.1 of the Home Health Manual lists numerous specific services which, if reasonable and necessary, can be considered qualifying skilled nursing services. Observation and assessment of a patient's condition and management and evaluation of a patient's care plan are included in this list and, we feel, are particularly relevant in light of the venipuncture provision. These services can be considered reasonable and necessary skilled nursing services in certain circumstances, as discussed in the manual and below.

Observation and assessment of a patient's condition by a licensed nurse: This is a reasonable and necessary skilled nursing service when the likelihood of change in a patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the patient's treatment regimen is essentially stabilized. Where a patient was admitted to home health care for skilled observation because of a reasonable potential of a complication or further acute episode, but has not developed a further acute episode or complication, the skilled observation services are still covered for 3 weeks or as long as there remains a reasonable potential for such a complication or further acute episode. Information from the patient's medical history may support the likelihood of a future complication or acute episode and, therefore, may justify the need for a continued skilled observation and assessment beyond the 3 week period. Where these indications are such that it is likely that skilled observation and assessment by a nurse will result in changes to the treatment of the patient, then the services would be covered. However, observation and assessment by a nurse is not reasonable and necessary to the treatment of the illness or injury where these indications are part of a longstanding pattern of the patient's condition, and there is no attempt to change the treatment to resolve them.

Management and evaluation of a patient care plan: This is a reasonable and necessary skilled nursing service when underlying conditions or complications are such that only a registered nurse can ensure that essential nonskilled care is achieving its purpose. The complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of licensed nurses to promote the patient's recovery and medical safety in view of the patient's overall condition. Where visits are not needed to observe and assess the effects of the nonskilled

services being provided to treat the illness or injury, skilled nursing care would not be considered reasonable and necessary to treat injury or illness.

In general, when determining if skilled services are reasonable and necessary the inherent complexity of the services, the unique condition and individual needs of the patient at the time of assessment, and accepted standards of medical and nursing practice should be considered. This determination should be made without regard to whether the illness or injury is generally classified as acute, chronic, terminal or one which often extends over a long period of time. In addition, skilled care may, dependant upon the unique condition of the patient, continue to be necessary for the patients whose condition is stable. Some services may be classified as a skilled nursing service on the basis of complexity alone, e.g. intravenous and intramuscular injections or insertion of catheters, and if reasonable and necessary to the treatment of the patient's illness or injury, would be covered on that basis. In some cases, the condition of the patient may cause a service that would originally be considered unskilled to be considered a skilled nursing service. This would occur when the patient's condition is such that the service can be safely and effectively performed only by a nurse. However, a service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a licensed nurse. Where a service can be safely and effectively performed (or self-administered) by the average non-medical person without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service although a nurse actually provides the service. Similarly, the unavailability of a competent person to provide a non-skilled service, notwithstanding the importance of the service to the patient, does not make it a skilled service if a nurse actually provides the service.

Conclusion

We believe there are some beneficiaries who had been receiving home health care with venipuncture as the qualifying service who may, in fact, have medical situations complex enough to qualify for home health due to a need for other types of skilled nursing services, including observation and assessment or management and evaluation. Some possible examples are included in the Thomas letter. If venipuncture was listed as the sole qualifying service for a patient whose medical condition is complex enough to require another skilled nursing service then we would expect the home health agency to submit a revised plan of care reflecting this. Assuming that this revised plan of care establishes a need for skilled nursing services, home health services would be covered. However, we are not expecting our intermediaries to make any *assumptions* about a possible need for skilled care due to a beneficiary's complex and fragile medical condition. The burden of documenting the patient's condition lies with the home health agency. If you examine documentation submitted by the home health agency and do not see evidence of the need for skilled services, you should deny the claim.

Established rules, as outlined above and in the Home Health Manual, clearly explain that many services, including observation and assessment or management and evaluation, can be considered

a skilled nursing service for the purpose of qualifying for the home health benefit if reasonable and necessary. These are particularly important to keep in mind in the context of the venipuncture provision. We hope that this discussion has helped to clarify existing policy and how it is to be applied.

Thomas Hoyer, Director
Chronic Care Purchasing
Policy Group, CHPP

Linda Ruiz, Director
Program Integrity
Group, OFM

Attachment

Addendum

Several questions about the interpretation of the range of services included in the definition of venipuncture have been asked frequently. This addendum will answer the most common questions regarding the scope of the venipuncture exclusion as a qualifying service under the Medicare home health benefit.

(1) Is drawing an arterial blood gas considered to be "venipuncture?"

No. Arterial blood gas (ABG) collection is a skilled procedure with considerably greater risk than venipuncture. For example, the patient is at risk of arterial spasm leading to ischemia or infarction of distal tissues. Less invasive techniques, e.g. oxymetry, do exist; so, the ABG collection must be medically necessary in order to qualify a patient for home health services. The ABG collection would be considered medically necessary only when less invasive testing would not provide the clinically necessary information. Please remember that this procedure requires special and expedited handling of the sample in order to provide valid information. The home health agency must have documentation of why it is medically necessary to perform the ABG collection in the home as well as documentation indicating that all samples were handled properly for the service.

(2) Is collecting a "capillary" blood sample from a "finger stick," which may also include "point of service" testing, considered to be venipuncture?

The question which most often arises concerns prothrombin time testing in the beneficiary's home by a home health nurse. Because this service is a direct substitute for venipuncture, producing the same information as would be obtained by collecting the blood sample through venipuncture, performing laboratory testing of "finger stick" samples will be considered venipuncture. Thus, this testing cannot be considered to be the sole skilled service to qualify a patient for Medicare-covered home health services. In fact, this testing requires less skill to perform than venipuncture, since beneficiaries generally can be trained to do this testing themselves. In general, "finger stick" blood sampling is considered to be venipuncture.

(3) Is drawing a specimen from a central line (e.g. a Groshung or MediPort) considered to be venipuncture?

Drawing from a central line to obtain a blood sample is venipuncture. However, it may require a level of skill beyond that of the phlebotomist. Drawing blood from a central line to obtain a blood sample is usually not medically necessary where peripheral access to venous blood is available. Where there is a concern about safety and/or sepsis, the line should be accessed for blood sample at the time of utilization for administration of medication. Where the need for a blood count prior to chemotherapy exists, it can be obtained through a finger stick.

Many of the patients who have central lines in place may require other skilled services. For those beneficiaries, a home health nurse can perform the blood draw, either by accessing the central line

or through conventional venipuncture. For homebound patients with a central line, who require blood drawing service, a phlebotomist sent by a clinical laboratory can perform the venipuncture and be paid under Part B. For the few patients who are both homebound and must have their blood sample taken through the central line, a HCPCS code will be created so that this service can be billed through Part B.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

The Administrator
Washington, D.C. 20201

DATE: February 3, 1998

TO: All Home Health Agencies Serving Medicare:

The Balanced Budget Act of 1997 enacted several Medicare payment reforms intended to ensure that enrollees get the care they need and that Medicare is billed correctly. I am alarmed by reports that some homebound Medicare enrollees are being frightened by inaccurate information about changes in coverage, and that some HHAs may be terminating care for Medicare enrollees and blaming the payment reforms. This letter provides clarification of reforms in home health payment to help you inform and care for Medicare enrollees appropriately.

The Secretary of Health and Human Services is required to establish an interim payment system while a prospective payment system is developed. This interim system establishes two types of payment caps: one is a revised routine cost cap per visit, and one is an aggregate cap based on either the average cost per beneficiary at each home health agency (HHA) and the region in which it is located, or the median of aggregate limits applied to other HHAs. HHAs will be paid the lesser of 1) their actual costs, as before; 2) the per visit cap; or 3) the aggregate cap.

The new aggregate cap reflects the typical utilization of home health services for each HHA during the FY 1994 base period established by Congress. It allows HHAs to balance the cost of caring for any one patient against the cost of caring for all patients. We believe all Medicare enrollees can be safely and effectively cared for under this payment system by HHAs that deliver quality care efficiently.

The Balanced Budget Act also makes clear that the need for venipuncture alone does not qualify a homebound Medicare enrollee for other home health services. Beginning February 5, 1998, homebound patients who need blood drawn but who do not qualify for home health services will be entitled to venipuncture services provided by laboratory technicians under Medicare's laboratory benefit. Homebound Medicare enrollees who need blood drawn and who also qualify for other home health services can continue to have venipuncture services provided by home health agency staff under Medicare's home health benefit.

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The Medicare Conditions of Participation require HHAs to provide accurate information to their patients about Medicare coverage and payment. Medicare enrollees must be informed about what services are and are not covered, and they have a right to participate in care planning. HHAs are not free to reduce the amount of care ordered for patients by physicians.

HHAs in Medicare are not allowed to discriminate against Medicare enrollees. If an HHA accepts non-Medicare enrollees at a given level of severity, it must also accept Medicare enrollees at similar levels of severity. HHAs that provide services to non-Medicare patients while refusing services to similarly situated Medicare patients risk having their provider agreements terminated and being barred from billing Medicare.

Any reports of HHAs misinforming beneficiaries or inappropriately terminating care for Medicare enrollees will be considered the basis for a complaint survey that could lead to termination of the HHA from Medicare.

I know you share our concerns on this issue, and I want to thank you for your continued efforts in trying to provide Medicare enrollees with the best care possible in the most efficient manner possible. I look forward to working with you on this and other important home health issues.

Sincerely,

Nancy-Ann Min DeParle
Administrator

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